the MODERN HOSPITAL

VOLUME 66 JANUARY 1946 NUMBER 1

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CONTENTS

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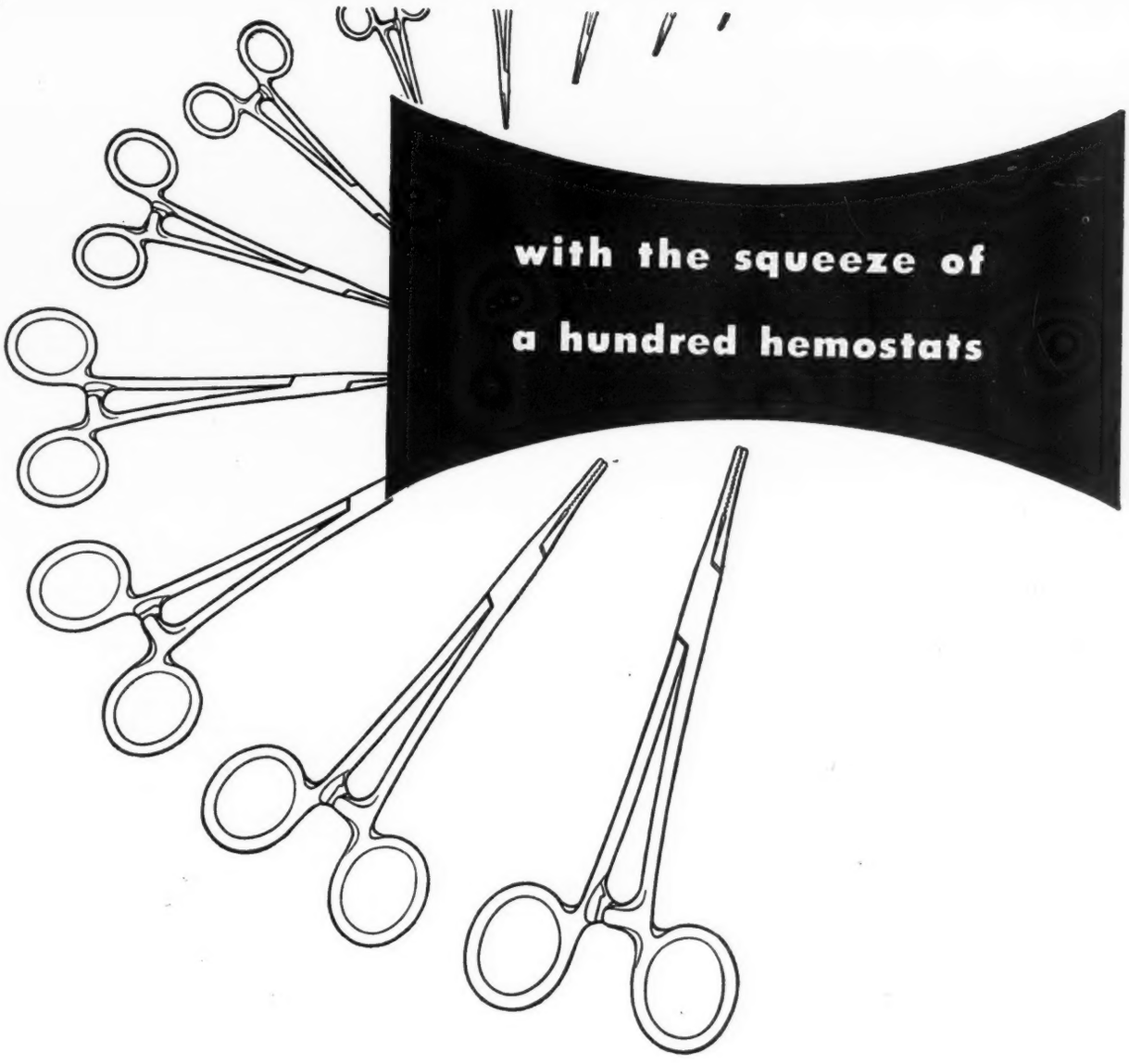

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THE ROVING REPORTER

Sweeping the Clouds Away

Your money or your eyes—either of these will speed the day when a Branch Eye-Bank may be established in your locality and when one out of a group of 25 blind persons may be made to see again through the remarkable corneal graft operation.

Lest all of you don't know it, the Eye-Bank for Sight Restoration was incorporated in New York State in February 1945. More than 30 leading hospitals in New York City's metropolitan area are its chief depositors.

Whenever any one of the cooperating hospitals has eyes available, it rushes them by Red Cross Motor Corps to Eye-Bank headquarters at 210 East Sixty-Fourth Street. There doctors and laboratory men make complete pathological examinations of the eyes, attend to their preservation and, if the corneas are perfect for grafting, distribute them in turn to qualified surgeons with suitable cases.

A surgeon is told when his turn is next and informs the first patient on his list, "who, with pounding heart, answers the call to rush to the hospital, the call that may well mean he will see again."

It is possible today to preserve the precious corneal tissue for seventy-two hours and the Eye-Bank for Sight Restoration hopes not only to establish branch banks in strategic centers but to establish a cross-country network for swift transportation of the tissue. Eventually the bank hopes to operate internationally.

Just now the Eye-Bank is asking also for money contributions; none is too small or none, too large. The money will be used (1) to extend and operate the machinery for collecting, preserving and distributing corneas; (2) to provide fellowships and scholarships to train eye surgeons to perform the corneal graft operation; (3) to support research.

If you wish to donate your eyes after death to leave sight to perhaps three blind persons—one piece of healthy cornea the size of a dime is enough for a single graft—you need merely fill out a blank, like the one below. You may have a defect in vision but if it does not affect the cornea, your eyes are still useful to those blinded because they live behind a cloud, a cloud that sometime you may sweep away.

Race Relations

Want to do your part toward better race relations? Here is what the welfare federation of New York City is urging upon public hospitals:

"Uniformly adopt the policy of serving all without discrimination and admit to your professional and administrative staffs qualified persons without regard to their identification with minority groups."

This recommendation, among others, was advocated at a hearing of the Mayor's Committee on Unity December 10.

Rates Are Visible

Smack in the center of its new 48 page information booklet to patients, Queen's Hospital, Honolulu, T. H., has an eight page insert printed on very thin, canary colored stock: its schedule of charges. Probably not all the large run on this booklet has been bound into the blue covers. When present charges get out of line, a new insert can be printed and bound in place. Another advantage of this arrangement is that nobody can miss the rate schedule, which is one of every patient's chief concerns. Visiting rules appear in the same insert, so they can't be missed either.

Happy Birthday to You

Sugar must be more plentiful in Middletown, Conn., than it is most places. Either that or else Middlesex Hospital is particularly eager to get back to one of its pet good-will builders. Anyway, Administrative Dietitian Donaldson announces that the practice of presenting birthday cakes to patients who spend their natal day in the institution has been resumed.

Democratic Designing

Looking ahead thirty-five years, Michael Reese Hospital, Chicago, is planning a medical center campus that will approach the ideal. A planning staff with Reginald R. Isaacs as the director has been at work on the project for several months and has already called into consultation some of the biggest men in contemporary architecture and city planning, Dr. Walter Gropius of Harvard among them.

But Michael Reese and Architect Isaacs have further widened their consultant list to include every employe of the institution. Comments can be given in person or anonymously, by telephone or by letter to the planning staff's headquarters.

The hospital's house organ is publishing some of the suggestions elicited by its own inquiring reporter and those from the ward helpers, housemen and orderlies are just as pertinent as are the suggestions of the medical staff.

Once the long-term goals are established, the planning staff will prepare two, five and ten year programs for development.

Keeping Those Volunteers

The patient may have read in the papers that the war is over but a certain doubt creeps into his mind when he becomes hospitalized. Nurses are returning to general duty slowly and a little reluctantly and volunteer effort is at something less than white heat.

This isn't true everywhere; we actually know of a hospital that has a waiting list of nurses, for the pay is good and the administration democratic. This hospital is not so concerned about loss of volunteer morale.

We know of some hospitals, too, where volunteer effort flows smoothly, uninter-

Form for Persons Wishing to Donate Their Eyes After Death

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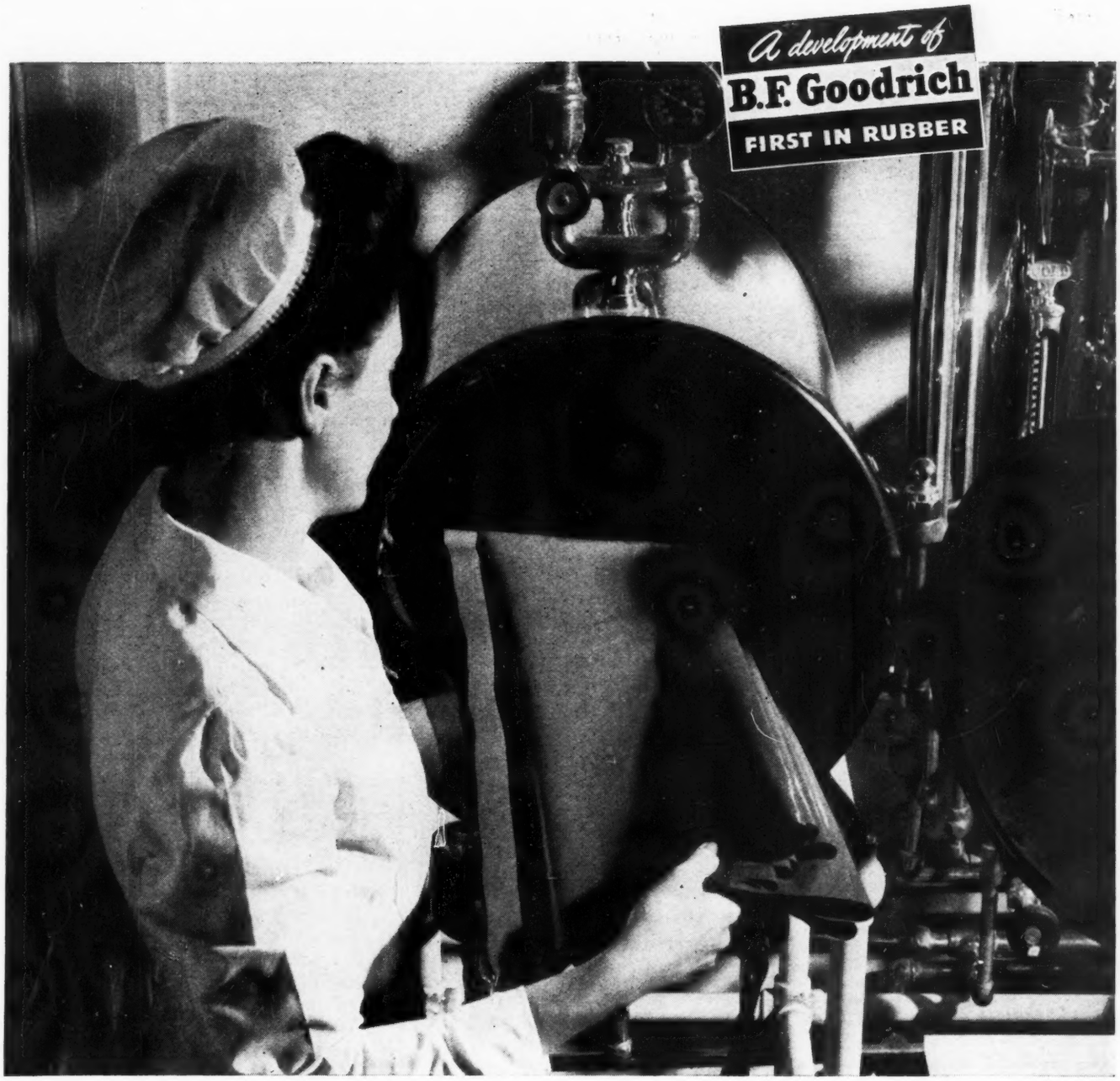
I herewith express the wish to donate to THE EYE-BANK FOR SIGHT RESTORATION, INC. (a New York corporation), at time of death, both or either of my eyes for such use as the said Eye-Bank may see fit with regard to all or any part of said eyes.

SIGNATURE_____ DATE_____

WITNESS_____

WITNESS_____



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ruptedly on. Let's see how this is accomplished:

At Fairview Park

Long before the war started volunteer work was a substantial and going project at Fairview Park Hospital, Cleveland. Thus it escaped the high casualty incidence of so many war babies. At least that is one reason Supt. Philip Vollmer Jr. gives for the high retention record of his volunteer staff. A second reason is the fact that the hospital keeps close to its volunteers so that they are convinced that each has a definite part in a highly necessary community service.

The Rev. Mr. Vollmer presents his views with considerable punch. Let's listen to him:

"We have always avoided the psychology of emergency or crisis [in dealing with volunteers]. This psychology, I believe, accounts for much of the juvenile delinquency in our American communities. We have a way of putting on full steam, raising a lot of racket, big publicity, loud talk, radio coverage backing up the newspapers, and then, having done all this along the lines of a political campaign or an old-fashioned emotional fund-raising effort, we think the job is done.

"Where this psychology has been used in building volunteer groups in hospitals, the same results have occurred, namely, a white heat and high peak of interest and endeavor followed by a low valley of disinterest.

"When we started volunteer work we assumed that it was going to be as much a part of the institution as the dietary department or the boiler house and our people caught this spirit, with the result that they see no reason for giving up now that the war is over."

At Fairview Park the volunteers do a wide variety of jobs, many of which require no special training. Many of the nursing vacancies that occurred with the war were filled by employing more paid nurse's aides who were given a short course of training. The school of nursing, too, increased its enrollment from 60 to 172. The knowledge that there were many volunteer posts open besides nursing made membership in the group more attractive.

Fairview Park Hospital is something of a family group anyway and doctors, nurses and lay employes like the volunteers and let them know it.

The hospital has given several teas and recognition meetings to volunteers and has distributed pins for 500 and 1000 hours' service and beyond.

"We don't mind letting it be known that we consider the volunteer valuable in interpreting the hospital to the community, as well as for the work she does," the Rev. Mr. Vollmer points out.

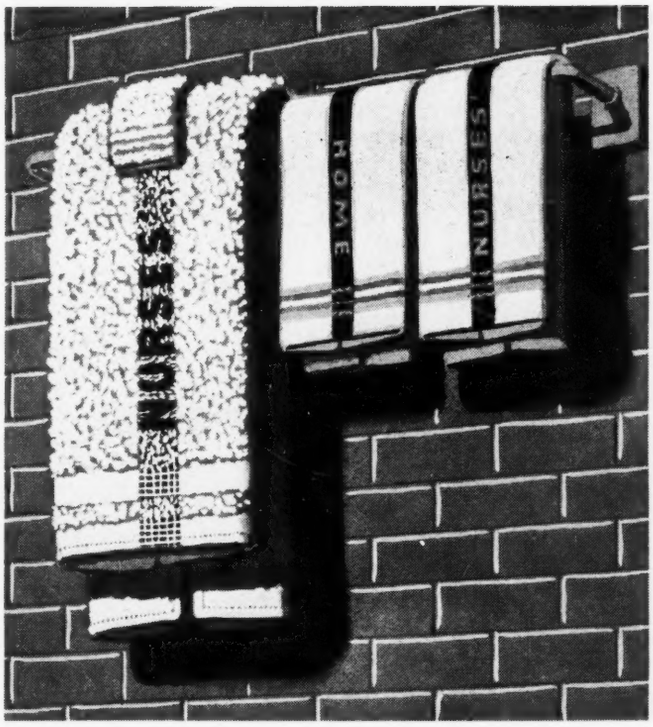
"A group as large as our volunteers with as many important connections as they have and with the willingness to sacrifice that they have demonstrated over the years can do much more than one might imagine to hold the hospital before the public in a favorable light. We value our volunteers as a link with the people of Cleveland, just as our patients, doctors, nurses and lay personnel are, and that makes them as least as important in our whole plan of operation."

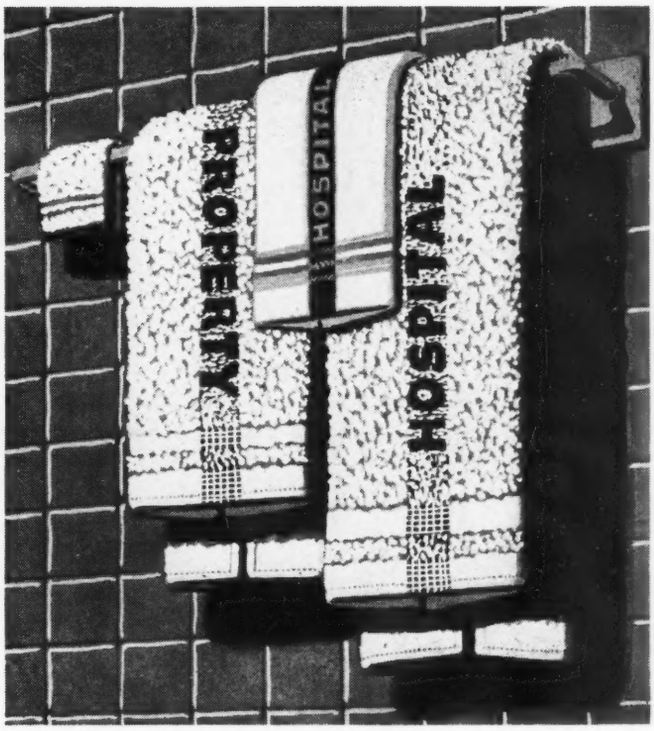
Prewar Stuff

Dr. Claude W. Munger recently told a gathering held in honor of volunteers that the volunteer program at St. Luke's Hospital, New York City, will continue to function there as it has for the last twenty-eight years. So saying he presented a Citation for Distinguished Service for from eighteen to twenty-five years of assistance to the hospital to Mabel Burritt, Gertrude Hoyt and Mrs. Willard Nellis of New York City and Mrs. Guy Richards of Woodmere, Long Island.

Farewell and Hail

A formal and graceful ending of the St. Barnabas Hospital volunteer program as sponsored by outside organizations took place in late November at St. Mark's Cathedral in Minneapolis.





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These war-time volunteers—Red Cross nurse's aides, dietitian's aides, staff assistants and Gray Ladies, as well as non-affiliated volunteers — have given St. Barnabas more than 25,000 hours of service in the last two years. Mrs. Fred B. Wells, chairman of all volunteer service at the hospital, has given more than 5000 hours. She worked from thirty to forty hours a week during the entire war period.

After the formal program in which each volunteer received a certificate of appreciation and those who had served an outstanding number of hours or who had perfect attendance records received special mention, refreshments were served to the volunteers, their families and friends and the hospital personnel with whom they had worked.

With such glowing records as these volunteers have accumulated, Supt. Martha C. Lockman reports that many of them are remaining loyally with the hospital until their services can be replaced with paid workers.

Nellie Gorgas, director of the hospital, hopes that some of these volunteers will remain to form a permanent volunteer corps to provide the extra de luxe service that the hospital's paid staff can rarely find time to provide.

Baby's Beads

One of these days a young mother and her baby will be sailing for Germany to join Lt. Albert Cushing of the American Military Government. This young mother and her baby can make this trip that will reunite the family only because of the baby's identification bracelet received at Allerton Hospital, Brookline, Mass.

Lieutenant Cushing had a terminal leave in late November 1944 before sailing for the European Theater of Operations. He reached home in time to escort his wife and their first child home from the hospital. When the proud father left he took with him as a good luck charm his daughter's bead bracelet.

One night last spring, the lieutenant and a fellow officer, during the mopping up operations in the Ruhr Valley, found a partially demolished house in which they could rest. Some of the furniture remained and among it was a bed on which the lieutenant stretched out wearily.

For the thousandth time since he left home he pulled the tiny bead bracelet out of his pocket to finger it like a rosary. The bracelet suddenly broke and the beads scattered over the floor. He jumped up to retrieve the beads of his good luck charm. Just then the bed exploded as it had been booby-trapped by the enemy.

The incident is told in the Allerton *Echo,* house organ of the hospital.

Warm Welcome

An electrically heated receiving crib awaits the new-born at Wentworth Hospital, Dover, N. H. No more reddened skins from contact with hot water bottles since Lesley Hoitt, the obstetric supervisor, took a course in caudal anesthesia. That gave her the idea that a crib equipped with electric light bulbs could be constructed by the hospital maintenance men to serve the infant.

Not one but two cribs were made, each with mercury switches to eliminate sparks which might cause fire in the delivery room where anesthetics are used. The lights in the crib are turned on when the mother enters the room and when the child is delivered, he is placed in the cozy crib. Chilling and shock are thus prevented.

It's Still a Good Idea

It isn't new but it's still infrequent, the granting of extra vacation time as a reward for long tenure. The historic Pennsylvania Hospital, Philadelphia, is one of those that grant an extra week of vacation to employes who have completed twenty years of continuous service. Nineteen persons rated that extra week in 1945.

READER OPINION

The Long and Short of Bluestone

Sirs:

I am sure that every reader of The MODERN HOSPITAL will be grateful for the subjective point of view which Eleanor McClurkin has so thoughtfully presented in the November pages of The MODERN HOSPITAL on the subject of chronic disease. Since she is scholar enough to quote from published work on the subject, and particularly since she has given my views on long-term hospitalization a generous section of the space allotted to her, I feel constrained to clarify my position on the subject for her benefit, as well as for the benefit of any other reader of my published work who may be under similar misapprehensions.

My thesis is this: that the care of the short-term patient and the long-term patient must be integrated in the general hospital (any hospital, anywhere) on a continuing basis, so long as the need for hospitalization can be proved. In my opinion, the natural history of disease should be studied in all of its phases, from infancy to old age, in a group of sections or buildings physically set apart yet organized under a unified plan with a free transfer of patients on short notice.

Long-term illness may be irksome but it does not, in itself, justify the rustication of a patient. I do not limit my thesis to either urban or rural areas. What is good for the one is good for the other. On the reverse side of the page on which the author interprets my views on the subject, appears a short paragraph from my pen reading as follows: "Never place an obstacle between the patient and his physician and remember that distance is an obstacle." I never singled out any specialty, such as orthopedic surgery, specifically. All specialties are alike to me and all specialties are, indeed, represented as much in long-term medicine as in short-term medicine. I might add that it is not enough to have the short-term patient and the long-term patient "under the same supervision." The medical care of both must be integrated, which means that the same visiting staff, the same social workers and, preferably, the same philanthropists should see through to the end the responsibility they assumed.

It follows from this that my plan for the "true medical center" is not limited to an urban community, nor does it require "a centralization of institutions where overhead costs are highest." I would be the last person in the world to ask that "all these cases be sent to a city medical center" from rural districts and I am in full agreement with the author that "it is unwise to remove such patients from their locality and friends" except under the most compelling medical circumstances.

E. M. Bluestone, M.D.
Director

Montefiore Hospital
New York City

Danger!

Sirs:

One of the youngest professions, nursing, is rapidly leaving the comparatively safe shoreline, where the tide runs quietly and gently, to wade out bodily into the midstream of new and revolutionary ideas. I refer especially to private duty practice, formerly one of the largest groups in the nursing field. In our hospital, only one graduate of the classes from 1941 to 1945 is doing private duty nursing, and recently published statistics indicate that nurses who have served in the armed forces have little desire or intention to return to civilian hospitals, much less to private practice. Perhaps this trend is overemphasized at the moment, but in my opinion it is here to stay.

If this is true, it seems to me that we must begin immediately to visualize hospital care on an entirely different level: We must be prepared to enlarge the general duty staff considerably. Hospitalization will increase, because few nurses will be available for home care. If hospital expenses increase, because of more nurses on the pay roll, hospital costs to the patient must also increase. If the burden of hospital care is already excessively heavy for Mr. and Mrs. America and family, there will be louder and louder cries for state and government assistance when the per capita cost of sickness increases.

Perhaps this is too pessimistic. Perhaps more hospital administrators would welcome socialized medicine than are now apparent, but to my mind the trend is significant and, like a snowball, it grows and rolls with ever increasing rapidity.

Helen Liddle Warren
Superintendent

Samaritan Hospital
Troy, N. Y.

Fine Pony

Sirs:

For months while I was overseas I thoroughly enjoyed your magazine's *News Letter*. I found myself looking forward to each new edition with much enthusiasm, and I want you to know how much I appreciated all of them. Congratulations on the "pony edition."

Often I read the latest issues of The MODERN HOSPITAL at Army, Navy and civilian hospitals. I found two copies at an Army Station Hospital on Iwo.

Capt. Arthur G. Burns, USMCR

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., People's Community Hospital, Eloise, Mich.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

How to Teach Attendants

Question: Many hospitals are short of nurses and must give several nursing duties to attendants. What is the best way to teach them their duties?—A.M., Neb.

ANSWER: It is difficult to answer this question without knowing more about the particular nursing duties that are being assigned to attendants and the character of the attendants, that is, whether they are full-time paid attendants or volunteers who work only periodically. In general, I would say any nursing duties and procedures must be taught by the director of nurses or her delegate. This might involve a certain amount of formal didactic instruction, as well as practice sessions, following somewhat the general order of training under the Red Cross nurse's aide program.—CARL I. FLATH.

Eliminating Icebox Odors

Question: How does one get rid of icebox odors which are not vanquished by routine soap and water cleansing?—F.L.T., Mich.

ANSWER: Investigate to determine the cause of the odors. If they are due to spoilage, remove the food or particles and clean the refrigerator well by washing with cool water to which has been added 2 tablespoons of baking soda, or borax, for each quart of water. This helps counteract food odors. Soap should not be used on the inside of a refrigerator as food may take the taste of soap.

If there is any wood inside the refrigerator or if the door facings are of wood, they should be carefully checked. Often the wood becomes water soaked and rots and thus causes odors.

Charcoal and various chemical materials on the market are also used to keep refrigerators free of odors.—DOROTHY DEHART.

Bactericidal Lamps

Question: Are bactericidal lamps technically successful and desirable in (1) out-patient clinics, (2) surgery, (3) nurseries (pediatric and new-born)?—R.B.A., Mich.

ANSWER: Long experience has shown bactericidal lamps to be technically practicable in all of the foregoing situations. Bacteriological tests prove that the hazard of breathing organisms coughed, sneezed or expelled into the atmosphere by other expiratory processes is greatly reduced. Dust-born bacteria are more resistant but most of these are harmless organisms in accumulations of decomposing organic matter which can be suppressed by cleanliness or removed by ventilation.

Clinical experience is less easily evaluated, but many reports on surgery and on children's and infants' wards and nurseries indicate a marked lowering of hospital cross-infection attributable to air. Since out-patient clinics accommodate infected persons, lights are indicated on general principle, and the same principle indicates the desirability of irradiating corridors. Many places in the hospital should be sunned with this purifying light.—WILLIAM FIRTH WELLS, M.D.

Precautions in Surgery Suite

Question: What precautions should be taken against explosions in the surgery suite?—G.A., N. C.

ANSWER: 1. Do not permit switches to be installed on the cords of electrical equipment. Current should be turned on or off by means of the attachment plug and wall receptacle; this should be located at least 4 feet above the floor and should be preferably of the explosion-proof type.

2. If explosion-proof wall receptacles are used, do not permit the use of adapters or extension cords having non-explosion-proof receptacles for connection to conventional attachment plugs. The use of such conventional connectors, which frequently lie on the floor, constitutes both an electrical and an explosive hazard. Under no circumstances should such connectors ever be permitted near or under the operating table.

3. If air-conditioning equipment is used, it should be so operated that carbon dioxide is *not* removed. Humidity is not a safeguard against electrostatic discharges unless there is carbon dioxide present to make moisture films electrically conductive.

4. Do not permit "sharkskin" uniforms to be worn in the operating room.

5. Do not permit woolen blankets to be used in the operating room.

For a complete discussion of this problem, consult "Safe Practice Recommendations for the Use of Combustible Anesthetics in Hospital Operating Rooms" published by the National Fire Protection Association, 60 Battery March Street, Boston.—J. WARREN HORTON.

Pathologist's Percentage

Question: What percentage of the net income should a full-time pathologist be paid?—F.W.J., Ill.

ANSWER: There can be no definite answer to this question. The compensation that should be paid to medical specialists employed by hospitals depends upon a number of complicated factors, such as the ability and personality of the physician, his length of service, the time he devotes to the hospital work and the progress made by the department under his direction.

The principles set forth in the article on page 46 of the March 1945 issue of The MODERN HOSPITAL should be kept in mind when endeavoring to settle problems of this kind. In essence these are:

1. The radiologist and the hospital should be treated fairly.

2. A partnership arrangement should be made.

3. The full cost of operating the department, including overhead expenses, should be ascertained so that no loss will result to the hospital under the contemplated agreement.

Any definite percentage is disadvantageous from two standpoints: (1) if the revenue from the department is very small the basis may be unfair to the pathologist and (2) if the work of the department grows through the years the contract may finally result in large payments to him. Theoretically, the best procedure is for both parties to sit down together with all the cards on the table and work out a mutually satisfactory arrangement.—ROBERT N. BROUGH.

Staff Should Approve

Question: Wouldn't it be necessary to consult with the active medical staff before engaging a house officer, especially in a small community of say 10,000 population?—S.W., Ohio.

ANSWER: A paid house officer must of necessity work for and with the staff. Therefore, it is essential that the physicians with whom the house officer works should approve anyone chosen for this position.—R. C. BUERKI, M.D.

Incomplete Charts

Question: What do you do with incomplete charts, when the doctor who is responsible for completing them dies suddenly?—R.C., Mich.

ANSWER: Attach a note to the chart to that effect and file it unless another physician had assisted on the case in which event I would ask him to complete it if he can.—EDNA HUFFMAN.

RECENT tests, made on patients in a large New York hospital, seem to pave the way for extensions of alcohol therapy in a number of new directions. If further experiments and experience bear out the highly successful initial findings, several new applications may well become parts of standard hospital techniques.

SURGERY UNDER SPINAL ANAESTHESIA — Intravenous injections of ethyl alcohol resulted in muscular relaxation of the patients. Fear was absent and there was no memory of pain.

NEW NUTRITIONAL USES — In cases of inanition resulting from nausea and intestinal obstruction, alcohol injections were used to increase caloric intake and so supply an added energy source.

CARDIAC CASES — When it was necessary to administer fluids intravenously to cardiac patients with elevated blood pressures, injections of alcohol expanded the blood vessels to the point where the added fluid in the system did not further raise the blood pressure.

DELIRIUM TREMENS — Intravenous injections of alcohol controlled delirium tremens, resulting from the withdrawal of intoxicants, when all other medication in the usual dosages had failed.

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LOOKING FORWARD

It Works Both Ways

DECLARING that strikes against hospitals are immoral, as well as illegal and inimical to the public welfare, Justice Ferdinand Pecora of the New York State Supreme Court recently granted an injunction sought by the New York Hospital to restrain striking maintenance employes. This ruling is in line with other court decisions and supports the widespread feeling that there is something indecent and inhuman about a strike which involves any possible hazard to the care or comfort of the sick and suffering. It is universally agreed that there must be no compromising the humanitarian purposes to which our hospitals are dedicated.

Neither must there be any attempt on the part of hospital management to use these humanitarian purposes as a screen to hide substandard wages and working conditions. The fact that hospital workers may not strike does not in any sense relieve management of a problem. On the contrary, it adds a serious responsibility.

If hospitals are to be thus set aside from all other private employers, they must see to it themselves that their industrial relations are modernized. Hospital wages must be the equal of wages paid elsewhere for comparable work. Hours must conform to the most enlightened practice in industry. Working conditions, including cleanliness, ventilation, lighting, safety and comfort, must be consistent with the best modern plants. Above all, the hospital employe, who is now to be denied the final recourse of strike as an expression of dissatisfaction, must be given systematic free channels through which to bring any grievances before the management, either as an individual or as a member of a union or other employe group.

In order to bring their personnel practices up to date, it may be necessary for hospitals to raise rates. No one is likely to make any serious objections if this is the case. If it is fair to demand that workers relinquish the right to strike, in the interest of patients, it is equally fair to demand that patients pay adequate rates, in the interest of workers.

The righteousness of the hospitals' cause will be destroyed if either group is made to suffer to serve the needs of the other. Through the courts, immunity from strikes is a gift to hospitals from the public. Hospitals now become answerable to the public for their treatment of employes, as well as patients.

Gratitude

EVERYONE has been grateful conversationally to the doctors and hospital administrators and nurses who went away to war. In a few places, practical ways of demonstrating this gratitude have emerged. In Pennsylvania, for example, the state medical society has established a non-interest-bearing loan fund to help doctors returning from military service reestablish their practices. In Detroit, a hospital is distributing notices urging patients to return as soon as possible to the doctors who served them before going to war.

Unquestionably, other means of lending a helping hand have been developed. We should like to hear about these, so that we may pass the worth-while ideas along —and thus do our bit toward paying a debt that will be on the books for a long time.

Will Our Dreams Come True?

WITH the advent of the new year, postwar planning, about which we have done so much talking, writing and thinking, has become a reality. Meditation now gives way to action.

Not that hospital progress has remained static during the last twelve months, far from it. In many respects it has been a year of outstanding achievement. We have learned, among other things, how well we can do without. We have learned how strong is the tie that binds the public to our voluntary institutions, as exemplified in the outstanding success of many fund-raising campaigns and in steadily growing Blue Cross enrollments. We have recognized the importance of new evaluations of hospital and medical service looking toward the coordination of existing facilities into a comprehensive health program.

We have recognized our blessings—also our limitations. More than ever before, voluntary hospitals need interpretation. Their complete story remains yet to be

told. They need to broaden their horizons, to seek wise counselors in the conduct of their affairs. They need sympathetic, interested and intelligently posted trustees. If they are to play a part in every man's life they need to come closer to those lives and to reach the heart of the community itself.

All these and numerous other manifest needs we have contemplated and discussed at length as part of postwar planning. Do we possess the power, the conviction, the faith to transform these plans into realities? The year 1946 will answer that question.

Let Them Tell You

RECENTLY, a hospital administrator wrote to all the women who had served as nurse's aides in his hospital since the beginning of the war. He pointed out that their work had given them an intimate, firsthand picture of the hospital's activities and urged that they suggest to him any needed improvements in the hospital's organization, equipment or functioning.

The result was a deluge. A few of the women contented themselves with a general statement that everything was fine or would be as soon as adequate personnel could be employed. But more of them had long lists of faults to bring to the administrator's attention.

Such a procedure holds possibilities of dynamite. The administrator himself may resent the criticisms and go sour on the whole idea of volunteers. Or the department heads whose services are examined may go on the defensive.

If the administrator and his staff can be big enough to take criticism and profit by it, however, there are very real benefits to be gained. In the first place, the administrator will often have good ammunition to take to his board or to the public to obtain improvements. In the second place, he can often himself take immediate remedial action before the situation gets out of hand and public criticism becomes acute.

Finally, the nurse's aides will often feel much better toward the hospital if they are convinced that the administration is sincerely trying to meet every criticism honestly and as effectively and promptly as possible. After all, isn't it better to have the aides tell our faults to us instead of to others?

Shape of Things to Come?

THE University of Illinois Medical School now has the largest number of women ever enrolled in its first year class; according to a university bulletin, nearly one fourth of the beginning medical students this year are women. Other medical schools also report growing lists of women applicants and students. One authority complains that many of these women will get sidetracked into marriage and household duties, but a recent survey shows that 85 per cent of women medical graduates are in some kind of professional work, so obviously most of the girls mean business. Calling Doctor Distaff!

Unanimous!

"I AM in favor of the care of the veteran in existing civilian institutions to the greatest possible extent," declared General Hawley in a recent issue of the *Journal of the American Medical Association*.

"We will have to expand and use community hospitals in order to do our job," Lt. Col. Harry Brown, director of hospital service for the Veterans Administration, told delegates at the American Hospital Association meeting in Chicago.

Doctors doing contract or consulting work for the Veterans Administration would naturally be pleased to see their veteran patients in near-by hospitals, where they are caring for other patients at the same time.

Hospital people have universally endorsed the principle of using civilian institutions for all veterans' care other than that of chronic or long-term illnesses.

Overwhelming as this body of opinion is, it isn't enough.

Ask any veteran who has traveled for miles to be hospitalized in one of the huge, gloomy veterans' facilities whether or not he'd rather be back home in his own community hospital.

That does it!

The Night Crew

THE most exciting and spectacular part of hospital life usually occurs in the daytime, of course. But the hospital employes who work the evening and night shifts hold important responsibilities. Because they are not around in the daytime when the regular administrative officers are on duty, they may be forgotten somewhat in hospital planning. It is harder to talk matters over with them and to obtain the benefit of their experience.

Decisions must often be made on the spot by the night superintendent. Hence it is important that the person who occupies this position, usually a nurse, be experienced, have sound judgment and exemplify the traits of faithfulness, kindliness and skill which the hospital wishes to personify.

If the administrator wants to keep his finger on the pulse of the hospital he must find some way of having regular contact with the night crew. Occasional visits to the hospital at night will help. Why not also have breakfast with the night crew once in a while? It will demonstrate to these workers that they are considered an important part of the hospital family.

Better Late . . .

AGAIN this month, The MODERN HOSPITAL is coming to you late because of unavoidable delay at the printer's. In spite of continuing difficulty, we are steadily gaining back the time that was lost during the printers' strike last fall; this month's magazine is earlier than last month's was, and next month's will be earlier still. Within a few months we hope to be back on schedule.

CHRISTIANITY and DEMOCRACY

Parallel Roads to Help for the Mentally Ill

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— Third Prize Winner in the Psychiatric Essay Contest —

I

THE TREATMENT OF THE MENTALLY sick is the complex outgrowth of the historical background of a society. It does not develop independently as a factor per se but is essentially influenced by the prevailing historical climate. It is based less on the progress of rational thinking than on the turn which deep seated emotions take in large masses.

To be sure, a more enlightened treatment in accordance with the state of scientific progress might be provided here and there, but such exceptional instances contribute but little to the general betterment of the plight in which the mentally diseased have found themselves for ages.

Certainly, legal provisions that mental disease institutions have to provide sufficient numbers of psychiatrists, psychologists and nurses per capita of the institution's population, adequate governmental inspections of institutions and the raising of sufficient funds will make our present day institutions more palatable to the humanitarian, but such measures will contribute only little to the actual improvement of the patient's treatment.

There Must Be a New Feeling

Unless reforms are to be mere lip-service, improved treatment has to grow organically out of a new attitude society must take toward that cardinal problem. It is not the brutality and neglect which have occurred in the care of psychiatric patients, deplorable and detrimental as they may be; it is the feeling of isolation and solitude in which the mentally sick have lived for ages which constitutes the fundament of their plight.

Basically man's attitude has not changed toward the insane, if such an obsolete term may be permitted, in the course of history. Occasionally an insane person might have been heralded as a prophet, welcomed as a bearer of new light; the large mass of those affected, however, were met by the horror and anxiety which their disorder aroused in their fellow men. The horror and anxiety aroused in those who do not deviate from the common sense of their times, when they face the deranged or think about mental disorder, are the great obstacles in the pathway of progress toward adequate treatment of the mentally diseased.

Fear prevents man from recognizing in the mentally sick the image of man. He rather makes the insane a new species unrelated to mankind, a new kind of creature outside the boundaries of sympathy. Man acts as if acceptance of the insane as a member of his own flock endangered him; as if admitting the fact that every person carries within himself the possibility of mental derangement would create an unbearable fear of approaching mental collapse.

However, the recognition that a disease is potentially present in the average man has sometimes a miraculous effect on man's attitude toward it. The greatest impulse toward mass treatment of tuberculosis probably arose from the discovery that every child growing up in a city undergoes an infection of this kind. Tuberculosis became an acceptable disease of which nobody was ashamed any more and, whereas the drawn-out treatment of the disease had been accessible only to the wealthy in earlier decades, very quickly proper steps for mass treatment were taken.

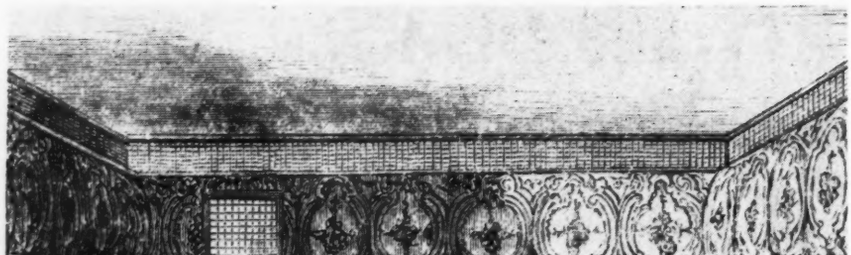
It would be wrong to refer such progress entirely to the progress of science. The change in psychological attitude probably was a far more potent motor. Because of it, society could identify itself with the disorder and, hence, more or less automatically, community responsibility integrated the problem. The same process can be observed in other integrative processes.

Up to a certain time society acted as if poverty were something like a disease or sin for which the bearer carried individual responsibility. The years of depression taught that the disease of poverty may befall any member of the community, that even the wealthiest is possibly a prospective pauper, and the ensuing years brought on a marked change in the citizens' attitude toward indigence. The poor were integrated into society; society felt a heightened responsibility for their welfare and did not hold the fact of their poverty against them. Communities became ashamed of the number of unemployed.

Mental Illness Is "Foreign"

A serious attempt to end the miserable conditions under which the mentally sick live in present day society, and have lived since man has formed the concept of normality, must start out with an attack on that basic attitude which is deeply ingrained in the mind of Western man, his belief that a mental disease is something essentially foreign to man, something concerning only a selected few.

Whatever man fears, he tries to rid himself of by projecting it away from the conscious segment of his personality; he denies it the right to be a part of his ego and treats it like something foreign, incomprehensible. He even fears an attempt at identification, which is the first step toward understanding. He rejects the idea of mental disease being understandable because, if he under-



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PADDED CELL IN AN AMERICAN ASYLUM

stood it, mental disease might then acquire the character of something human, which his own personality could be capable of producing.

Frequently, the belief is encountered that the fear of becoming insane is the first sign of a mental disorder. This, however, is quite contrary to man's usual conclusion in the presence of fear. The syphilophobic applies protective measures. The fear of a disease is never taken as a sign of the presence of that disease except for the one instance of mental disorder. Contents of fears express possibilities of human conduct. Hence, the mere fact that a human being weighs the possibility of a mental disorder as expressed in his fear of it is considered as a sign of such a mental disorder.

The underlying philosophy is that only an insane person can assume that such disorder could befall him at all. The entirety of that rigid attitude, the total denial of mental disorder being a human event, within the range of possible life experiences of any human being, is distinctly expressed in this philosophy.

Such attitudes express the extreme unconscious fear man has of mental disorders. He suspects that his adjustment to society is only the chance result of thousandfold processes over which he has no power, that the sanity he is so proud of is only a veneer. In sleep and dreams he experiences the necessity for regression, the expression of disgust with the world of his conscious ideation. When man is tired and falls asleep, he is tired of the world and finds nothing in it which might make it worth while to stay awake.

The patient suffering from a mental disorder is not ashamed of his regression. He demonstrates it unmistakably and does what every man unconsciously desires and would like, but fears, to do. He surrenders to the attraction of regressive forces. Hence, man's aggression against the mentally diseased, hence his eternal cursing and calling crazy and foolish whenever he notices unpleasantness in his fellow men. The reference to mental disorder with a disparaging term is the everyday expression of man's hatred of the deranged and his perpetual fear that he might lose control over the thin layer of adjusted behavior.

A comprehensive plan to reform the evil conditions under which the mental disease patient labors has to aim at a profound change of this attitude in man. The phenomenon of insanity must be integrated by society. The two main roads to perform this integration are given by the philosophy of Christianity and of democracy. I do not refer to the purely religious aspect of Christianity, such as rituals or certain basic religious beliefs, but to that part of Christian philosophy which is binding for human conduct in man's attitude and dealing with his fellow man.

II

THE BINDING RULE OF CHRISTIAN philosophy is the acceptance, care, protection and respect of human life in whatever form it might appear and whatever manifestations it might show. Man is asked to discover in every human being the presence of that human quality which is equally distributed throughout the species. Whatever devious turns and twists the soul might take, there is no room for outcasts in Christian thinking.

Man may not evaluate the soul and classify it as good or bad; he may not select among men those to whom he wants to turn his love because they arouse his sympathy; no, man should engulf indiscriminately the entire range of human variations with Christian love of fellow man. The study of history reveals how strongly human nature opposes the full integration of this principle. The rule originally combated two basic patterns of conduct in ancient society: the attitude to slaves and women.

Women Have Been Accepted

Since culture has been for ages masculine, and since groups meet with hostility those which are different from them, ancient philosophy did not accept men and women on equal terms, and Aristotle pronounced the permanent inequality of the male and female. After long detours and occasional relapses (even the council of Nicaea in A.D. 325 declared women to have no souls), Western society accepted the integration of women into society on equal terms with men.

The counterpart of the ancient slave in our society, the economically underprivileged laborer, still continues to live under most unhappy conditions; yet, likewise, in his instance society accepted the Christian tenet; he is considered a human being essentially the same as all the rest. No person today would accept Aristotle's word: ". . . although the parts of the soul are present in all . . . they are present in different degrees. For the slave has no deliberative faculty at all."

Christianity has made it impossible that a group which was exposed to its teaching for a sufficient length of time to be imbued with it could revert permanently to such judgment

toward any economically underprivileged group. Whatever the function of a man may be in the intricate mechanism of modern society, this function per se will not be taken as a classificatory element in terms of man's nature. This may appear self-evident to most contemporaries, but modern man is not aware that it is the expression of a long and painful cultural process which has not yet achieved its full goal.

Each time the Christian principle extends to new groups and a society faces the task of integrating a new class of outcasts, it balks and rebels and goes into a frenzy. Man is extremely parsimonious with his love and opposes the idea of letting it flow all over the world to include all human beings. Man tries to create new discriminatory elements which will enable him to separate others from his own group and to cast aspersion on them.

There is an intrinsic need in him for the comforting feeling of superiority created by membership in a group which he considers superior. Such membership results in merit without effort and is a seeming guarantee of permanency. Hence, the upsurge of national, racial and religious biases. A church, a nation, a race to which a man belongs is considered as superior per se.

Nationalism on the Decline

At present, however, we approach the end of the historical period which used such data for discriminatory purposes. Nationalism, racial and religious intolerance, though they may enjoy a great many minor renaissances, are declining. Neither do they hold their full sway any longer nor do they seem to satisfy those basic needs out of which they were born centuries ago.

We do not know what new discriminatory stigmata man will invent to buttress his feeling of superiority in the future. But the stigmata of slavery, the biases of nationalism, race or religion are ephemeral expressions of man's propensity of isolating "his" group from the rest of mankind. Such data are used transitorily in accordance with the change of historical periods. They do not primarily grow out of deep-seated fears. They are cherished for the sake of narcissistic gratifications.

Discrimination against women and children comes closer to basic biological insecurities, yet the perennial stigma throughout the course of history which man used to buttress his self-confidence and abate his fear is the stigma of a mental disorder. No torture seemed sufficiently painful to satisfy man's rage against this group. True, the process of civilization resulted in some humaneness of treatment during the last two centuries, but society is still far away from the Christian principle of conduct toward that group.

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SCENE IN OLD BEDLAM

Man's attitude toward the mental disease patient is a glaring breach of the Christian tenet. In the insane, man's veneer drops off, and the human plight appears in its nakedness. To raise a hand against him or to cast aspersion on him is tantamount to rebellion against the fundament of the human personality. But to accept him and to feel throughout the time of his withdrawal from our world the exquisite humanness of that process and the revelation that the usually concealed conflict is typical of the human mind fulfills the demand of Christianity.

The step toward the integration of the insane into society and into the feeling and thinking of the individuals in it will be the hardest among all past and future integrative processes. When it is accomplished, Christianity will have fulfilled its mission, because this group will be the last of all the outcasts. When Christian love of fellow men will have absorbed the insane into its realm, society will know that no other group of outcasts is waiting outside and begging to be admitted into the community of brethren.

III

THE COUNTERPART TO CHRISTIAN philosophy in the variety of Western political systems is modern democracy, yet its essence still refuses to be formulated as a theoretical principle. It is too young, too undigested to find a generally accepted formula. I venture to believe that the principle of individualism comes closest to expressing the essential nature of democracy. It is the guarantee that each member within its group and, in the last analysis, every human being will be provided with the opportunity of developing his own individuality to the maximal extent. The only acceptable limitation to such furtherance of individuality is prescribed by the frailty and weakness of human nature itself.

Democracy attempts to obviate all material, mental or spiritual factors of extraneous nature which might interfere with developmental processes necessary for the full growth, activation and realization of the human personality as an individual entity. To express it in positive words: democracy tries to provide each group member with the maximum of conditions favorable to the development of individuality.

Depends Upon Two Factors

These conditions are variable and mainly dependent on two factors: the scientific knowledge of the nature of the favorable conditions and the highest level of individuality obtainable in different historical periods. Every historical period breeds its own character, and the contents of individuality vary in accordance with prevailing historical tasks and problems. Far from having reached this goal at present, true democracy should be constantly developing toward it, even though its full realization may not be possible unless human nature should undergo an essential change during coming milleniums.

A set of obstacles similar to those encountered in the realization of Christian philosophy stands in the way of the stride of democracy: the stubborn belief of every individual that his own way of life, interpersonal relationship and personality expression is the only valid one, his intolerance of anything foreign to his own emotions, the ridicule and disparagement with which he meets conduct which does not fall within

the boundary of his own narrow self.

Man's narrowness in accepting and understanding manifestations of emotionality foreign to his own ego is excessive and constitutes one of the greatest dangers to the full growth of democracy. Show a man the clothes his ancestors wore 40 years ago, let him read the books they cherished, show him a motion picture he himself enjoyed 15 years ago, and he will smile with a feeling of superiority. He will not discover in such things the individuality and meaningful manifestations of the human mind which these choices represent.

Individuality a Burden

Individuality is a burden to man. Inertia prefers to take a nap tethered to convention. Individuality may lead to disagreement with one's group or surrounding groups, it may lead to struggles which, constructive as they may be, are not aspired to by many. Man does not feel the urge to respect the individuality of beings entrusted to his care. He longs to make others similar to himself, since he regards himself as supreme arbiter of what is good and bad, reasonable and unreasonable. He tries to force his fellow man into complete compliance with the rigid mechanism of social machinery, and the preservation of this machinery is more important to him than the flourishing of the individual whose welfare it should serve.

It took years of indoctrination before a child was permitted to use his left hand in writing. Even such an insignificant concession to individual propensities threw man's calm off balance and made him fear that the child might rebel against more important tenets if permitted in such trivial items to be what it really is and wants to be. So man draws the circle of what human beings should be allowed to do narrower, until man is degraded to a machine and until individual personality is smothered in a rigid armor which permits only one movement; and the process of growth is perverted. But such heavy chains may become too heavy and might be thrown off, and the long-suppressed breath of the living soul will exhale.

The human being, until recently obedient, suddenly refuses to follow the social pattern. He does occasionally what society permits only the artist to do, namely, express himself in his own individual language. In the case of the mentally sick, not only does the maltreated being start to speak his own language but he wants to act in his own individual way and refuses to believe what the majority tells him to be true.

The frightened bystander solves the dilemma by calling this strange behavior a sickness. He makes him an outcast. He banishes him from community life and refuses to recognize that the so-called disorder is nothing more than the dream of the sane, a very personal, individual configuration. It is beyond the grasp of the average individual that a mental disorder is the result of a removed inhibition, that now and only now the patient can talk and express what was brooding in him for many years and that thus he reveals his true, individual nature.

A mental disorder is not taken as an opportunity to catch a glimpse of the complicated working of the mind; no, as language expresses it succinctly by saying, "he lost his mind," the popular view is that the disorder is a deficiency, a loss which can be described only in negative terms. The demand for therapy and cure is raised. And certainly, the mental disease patient should be restored. He squanders his energy in soliloquism and self-indulgence.

Society, however, does not demand his restoration out of sympathy with him or because it wishes to regain the constructive participation of one of its members. No, the motive is intolerance. Nobody's behavior must deviate from the accepted average. This intolerance, this unwillingness to accept individuality, obstructs the cure. The mentally sick feels the opposition surrounding him, the lack of love and care about him, the environment's demand to see society's goal enforced and, hence, he withdraws more and more into deeper abysses of his own world where nobody either dares to follow or is capable of so doing.

Were he accepted as he is, were he to meet a companion who willingly shared his voyage into a world of dreams, one who did not want to impose the world of sanity on him, he would be given a chance to try to return. Paradoxically enough, the zeal to cure the mental case undoes the well-meant effort; this zeal, this intolerance, leads to the impatience, roughness and coldness met in most institutions.

Could we forget about therapy, we might be able to give him assistance. Could we give him the feeling that he is loved as he is, that he will remain loved and accepted, that he is a valid, respected member of the all-embracing community of human beings, he would stretch out tendrils toward companionship with others. Yet the integration of the insane as an individuality, the acceptance of his conduct as a valid pattern of human behavior, the respect for his individual manifestation will be the last success of the democratization of our customs.

All sorts of human behavior will be tolerated and integrated into the community when the privilege of taking refuge in insanity will still be considered a spiritual offense. As with Christian philosophy, it will be a triumph of democracy when society will accept a mental derangement as a turn in a man's struggle for individual expression and will be able to witness such struggle with the composure and calmness with which we watch our children learn to read and write or with which we listen to the words of a poet who is ahead of our times and expresses a feeling or a thought which will be fully understood only by a generation to come.

IV

I DO NOT KNOW TO WHAT EXTENT this view on the connection of democracy and Christianity with the treatment of mentally sick patients will meet agreement, but even if it does, I am certain that the question will be raised how recognition of this connection might contribute to the betterment of the conditions presently prevailing in society's conduct toward the mental patient.

True enough, when we consider the history of any such problem, we observe regularly that improvements which were made were never instituted out of idealism. Some few in the crowd might have been driven by idealistic motivations, but reforms on a broad scale requiring active participation of large masses were instituted by dire necessity only, or because they promised to be of advantage to a socially active and strong group. How can we expect that society's interest should turn toward the problem of the mentally

sick? Aren't they, the scum, though pitiable and worthy of our sympathy, in the last analysis superfluous, a burden? Might not society fare far better without concentrating and expending resources on their welfare? Aren't they a danger to coming generations?

If improvement of the care for the mental disease patient depended entirely on idealistic motivations in broad masses, there would be but little hope that active reforms would ever be instituted. The first step in a broad program of reform is to convince society that a new outlook on the problems of mental disease patients is required for the sake of society, that it is not a matter of charity or of an abstract ideal but a matter of survival.

Society must be made to realize that it is not for the patient to be grateful to society for privileges received; it is rather for society to be thankful that the patient returns recovered to the community.

It Is Society's Concern

If clean water is dispensed to city populations, if adequate hospitals are built for the medical care of indigent masses, this does not necessarily serve charitable purposes; it is a matter of fundamental concern to the entire community. Without adequate water supply, without adequate facilities for hospitalization, epidemics will sway the entire community, and the wealthy and the poor likewise will be doomed. The community is an organic whole and parts of it can flourish only when the whole flourishes.

What holds true for physical hygiene holds true for mental hygiene. The greatest empires, constructed on a firmer basis than anything Western civilization has to offer at present in skill of political organization, such as the Roman Empire, crumbled to pieces because their integrative forces were inadequate. The outcast, the outsider, whether slaves or economically underprivileged citizens, became an intolerable burden.

A similar problem will face our civilization. As soon as expansion in space is obstructed because geographical barriers are met and thus physical absorption of the outcast finds an end, the tremendous task of social and cultural integration arises. If this task is not accomplished, political stability is endangered, unrest looms and the danger of social disintegration threatens.

Since resistance toward integration of the mental disease patient is the deepest, the most archaic among all resistances to integration of groups of outcasts, it is reasonable to assume that if society's conscience is kept permanently aroused toward the goal of integrating the mentally deranged, all other groups will be absorbed in the course of this one integrative process. It will be necessary to teach society that in terms of its own survival a changed outlook on mental disease is a matter of self-interest and necessity; it is not based on an abstract humanitarian ideal.

The treatment of the mentally sick is a gauge, a measure of the level of democratization. Any lag in the process is followed by severe punishment. As long as any group of people is allowed to stay outside of the group-responsibility and group-conscience, democracy has not yet been fully established. Those archaic and uncivilized forces which persistently threaten the coherence of a democratic group are not only active but effective, and we cannot rest assured that democracy has really become an indelible factor in a political organization.

The program as outlined is a task concerning not only the present generation but many to come, for it aims at the very root of the problem as it grows out of the factors in human nature which are opposed to the continual growth of Christian philosophy and democracy. Every new step in the enlargement of Christian love for fellow men has to be achieved in a hard struggle against selfishness and lethargy.

Mental disease is a curse to those who suffer it, and a grief without end to those who witness it, but it may greatly benefit society. As electricity, a destructive force in lightning, is used in machines as a constructive power for the enrichment of human life, mental disease, an inherently disintegrating and destructive force, might be turned into a benefit to society if it were to become an exercise in tolerance and love. A practical program of great import to the community could result from facing this task.

The medical profession is increasingly accepted as an advisory agency for the whole community. There is scarcely a problem or conflict within a modern community which the physician is not invited to consider. His opinion is a pertinent contribution. Especially since psychiatry has been integrated into medicine, the scope of those subjects to which the physician can and must contribute is tremendous.

If the medical profession keeps the group-conscience aroused and persistently indoctrinates the community as to the link between Christian philosophy, democracy and attitudes toward mental disorders, the welfare of those patients who require institutionalization will be guaranteed. Not only will legislatures enforce the necessary steps and the community contribute the required funds but the atmosphere will change within mental disease hospitals.

Brutality, disinterest and unfriendliness will automatically disappear because the ethos of society will have embraced the image of the insane. The patient affected by a mental disorder will be drawn toward a community which respects his individuality and meets his disease with Christian love.

The question will be raised, and rightly, whether our community is ripe for such development. Will the physician who presents such a program be the butt of jokes and ridicule or will he be understood? Is the hostility against the mentally sick so great that it cannot be pacified and will society leave such advice unheeded and be deaf to the warning that in the interest of its own growth and survival it must basically revise its customary attitude?

The Poets Give the Answer

Let us turn to our poets for an answer. If they express similar thoughts and are understood by the public, the professional man will be able to crystallize in action that which they have created as a sentiment only. The following lines by Walt Whitman express the basic attitude which every one of us should try to develop, in order to put an end to a tragic chapter in the history of man.

"I find letters from God dropped in the street, and every one is signed by God's name.

And I leave them where they are, for I know that where'er I go, others will punctually come for ever and ever."

Life Begins in Safety in this remodeled nursery

SIDNEY M. BERGMAN
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IN PLANNING new nurseries and in remodeling old ones, an attempt should be made to close all possible avenues for infection, with particular reference to impetigo, infectious diarrhea and respiratory infections.

These avenues can be closed in two ways: (1) by physical improvements and (2) through the adoption of an isolation technic, the success of which depends upon complete cooperation and understanding by the entire staff, including nurses, interns, attendants and physicians, and also through the education of visitors.

In 1941, when I was executive director of Sinai Hospital in Baltimore, I redesigned the obstetrical building. Included in the remodeled building were several nurseries in which were embodied certain basic improvements in nursery design, for which I was indebted to Dr. Henry M. Pollock, then director of the Massachusetts Memorial Hospital in Boston.

At the 1939 meeting of the New England Hospital Association, Doctor Pollock presented a paper, discussed by Dr. Herman C. Petterson, chief of the pediatric service of the Massachusetts Memorial Hospital, entitled, "Nurseries and the New-Born in Hospitals."

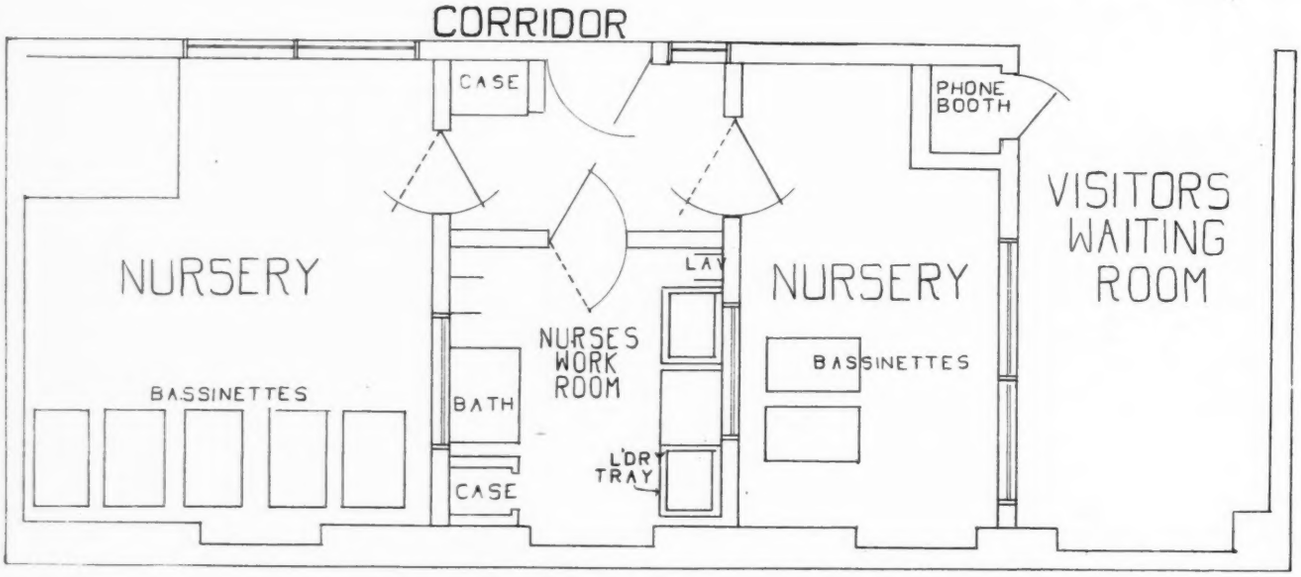
This paper described methods originated by Doctor Pollock to prevent the recurrence of infectious diarrhea in the W. W. Backus Hospital in Norwich, Conn., which had been brought about indirectly by the breakdown of facilities caused by the hurricane of September 1938.

The outbreak of a similar epidemic in Massachusetts Memorial Hospital shortly afterward from causes which could not be traced led to the adoption in both hospitals of the measures presently to be described.

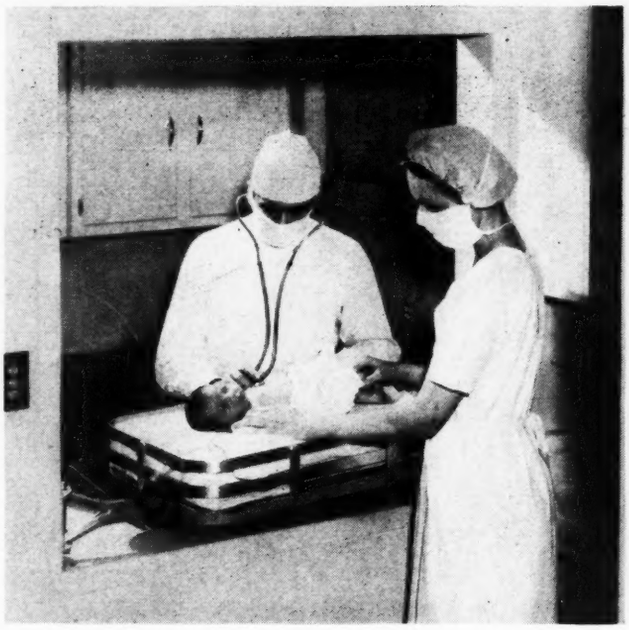
Following a quarantine of approximately two weeks, or until all maternity patients had been discharged, and during which period no new cases were admitted, Doctor Pollock renovated and repainted the nursery and reequipped it with specially designed bassinets on individual carriages placed in individual cubicles. He instituted the autoclaving of formulas; the exclusion of all personnel from the nursery except trained nursery attendants; the examination of infants through a special window opening which prevents the physician from entering the nursery, and established a simple and effective routine for individual isolation which would remain unbroken day or night. These procedures have led to a marked reduction in morbidity and mortality in the years following.

In planning the nurseries at Sinai Hospital, I designed a special bassinet, the carriage of which could be rolled out to form an individual work surface on which to carry out nursing procedures. Below this working surface a drawer was provided to house an individual treatment tray. The bassinet was built so that it could be placed in the Trendelenburg position or reverse. Beneath the working surface a compartment for linens was provided and in front of the bassinet a special receptacle was placed in which a stock paper bag could be inserted to receive soiled material for sanitary disposal.

The nursery suite included a formula room with provision for the autoclaving of formulas and a physician's examining room which provided access to infants through a window opening fitted with a special swinging shelf that permitted the physician to examine the infant without entering the nursery proper. The special design of the bassinet determined the arrangement of the cubicles in the nursery proper. They



NURSERY BEFORE ALTERATIONS



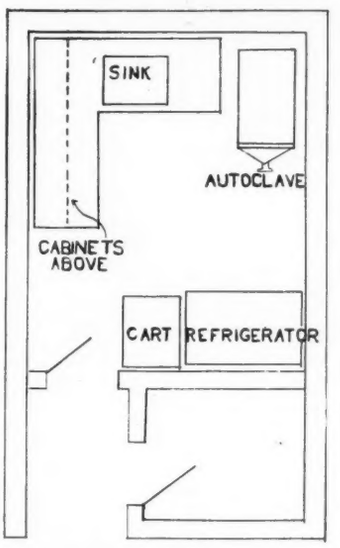
View from the nursery to the doctors' room, illustrating technic used in examining the infants.

The remodeled nursery, showing the arrangement of cubicles and a nurse caring for an infant.

ran the length of the room back to back and were surrounded by an outside aisle which gave free access to each cubicle for nursing procedures.

With slight modifications, the nursery technic of the Massachusetts Memorial Hospital nursery was adopted, with the endorsement of Dr. Alan Guttmacher, chief of the obstetrical department in that hospital and associate professor of obstetrics at Johns Hopkins Medical School.

The following morbidity statistics are illustrative of the results.

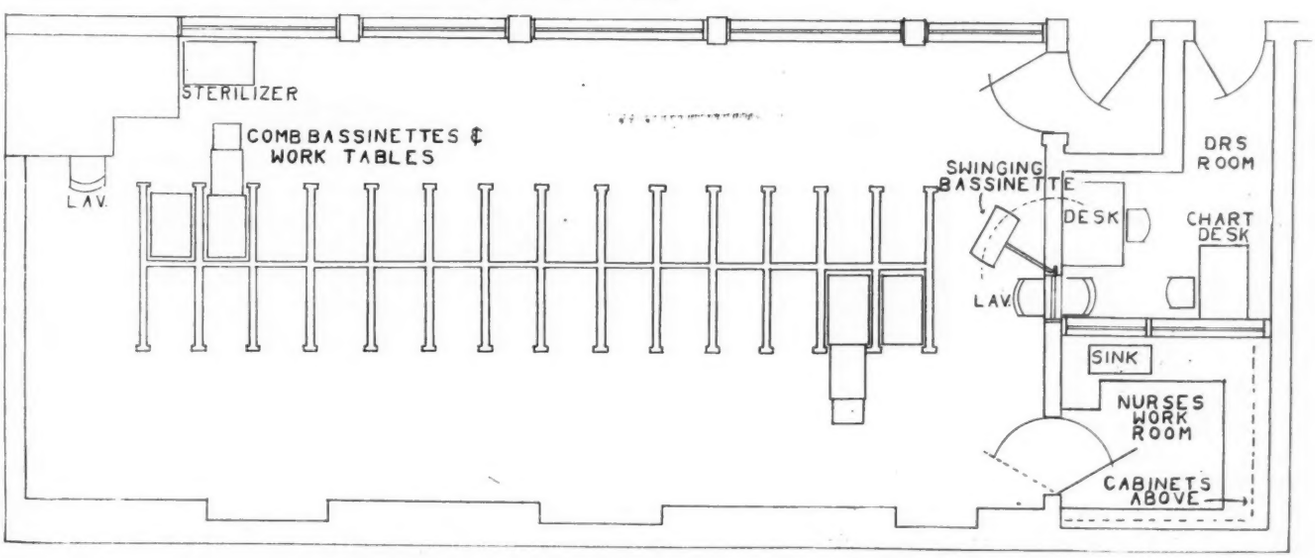


In 1939 there were 713 new-born admissions to the old nursery. During the year there were 12 cases of diarrhea, 11 cases of impetigo, four cases of thrush, one case of pneumonia.

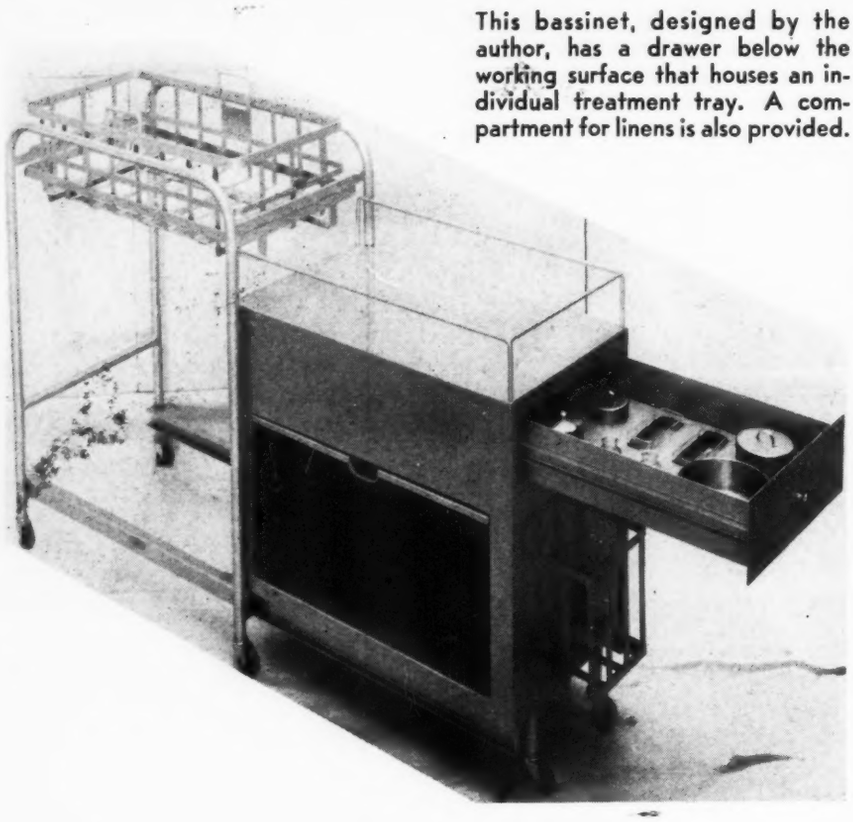
In 1940 there were 853 new-born admissions to the old nursery. The recorded morbidity was: thrush, one case, atelectasis, one case, impetigo, three cases, pneumonia, one case.

In 1941 there were 843 new-born admissions, with one case of atelectasis and two cases of thrush.

In 1942 there were 1156 new-born admissions to the nursery. Up to



NURSERY AFTER ALTERATIONS



This bassinet, designed by the author, has a drawer below the working surface that houses an individual treatment tray. A compartment for linens is also provided.

May 1, two cases of atelectasis were recorded; thereafter there was no morbidity during the year.

In 1943 there were 1430 new-born admissions to the nursery. During this year there were no recorded infections. It is of interest that during this period infectious diarrhea was prevalent in the city.

Montefiore Nursery Remodeled

In October 1945 I completed a similar nursery with some additional improvements at Montefiore Hospital in Pittsburgh. A detailed description of the nursery follows.

The nursery before remodeling consisted of two rooms holding 14 bassinets each, separated by a workroom with the doors to each room converging on a small vestibule. The workroom contained the customary cupboards, warming cabinet, bathing table with mixing valve above, baby scale and work sink, all of which presented opportunities for possible cross-infection.

While the bassinets themselves were single, they consisted of a basket on an open stand and were not separated by cubicles. Frequently, an overflow made it necessary to crowd the bassinets until they touched. Formulas were boiled in bulk and decanted into previously sterilized bottles, after which previously sterilized nipples were attached. These procedures also provided opportunities for breaks in technic.

In the renovation proceedings the interior walls of the whole area were removed and the nursery space was lengthened by the addition of an adjoining waiting room that was utilized to provide additional space for a doctor's examining room, which has a separate entrance to the corridor but no access to the nursery except an open window provided with a swinging shelf.

The pediatrician enters the examining room, scrubs in a scrub sink provided, dons a sterile mask, cap and gown and requests of the nursery attendant the infant he desires to examine. The baby is brought to the window by a similarly prepared nursery attendant and placed on a sterile paper mat on top of the swinging shelf, which provides a suitable examining surface. All diagnostic instruments desired by the doctor are kept as sterile supplies in the nursery and are passed through the window as needed. Doctors are not permitted to use their own instruments.

The nursery proper consists of a rectangular room provided with 28 cubicles made of pressed steel with laminated safety glass walls placed back to back longitudinally down to the middle of the nursery. This arrangement permits the nurse to treat each infant as an isolation case by drawing out from beneath each bassinet the integral work table and further to draw out from under the table the treatment tray. In this way the nurse caring for the baby has within arms' reach everything needed for individualized care.

The nursery is provided with an acoustically treated ceiling, the individual blocks of which are fastened to wooden strips embedded in the plaster by four lag screws each to prevent the accidental loosening of the blocks.

Lighting is accomplished by six individual fluorescent units operating on separate switches so that only one section of the nursery need be lighted at a given time. The fluorescent tubes in these fixtures are covered by corrugated glass housings which not only diffuse the light but act as a safeguard to catch powdered glass in the event of the accidental explosion of a fluorescent tube.

The nursery is provided with ducts for air conditioning in which ultraviolet light tubes are to be installed, so that as the air is recirculated through the ducts it is resterilized. A constant temperature of 78° F. is maintained by thermostatic controls set in the walls.

Provision for Incubators

Twelve of the cubicles are provided with electrical outlets to permit simple incubators to be fitted into the bassinets for the care of premature babies. At each end of the nursery scrub sinks are provided so that nursery attendants can conveniently scrub before caring for each infant. Leading from the nursery is a small but very compact workroom providing ample storage space and facilities for washing and sterilizing equipment. The weighing of babies is accomplished by a scale mounted on a traveling carriage that can be moved down the aisles for the weighing of each baby in turn upon a sterile paper mat.

The formula room contains a work table with stainless metal top fitted with a stainless metal sink, where the cleaning of bottles and nipples is carried out, as well as the preparation of the nonsterile formulas. Adequate cupboard space is available for supplies.

An autoclave that is set to operate at 7 pounds' pressure is provided. A

32 cubic foot electric refrigerator is used for the storage of the autoclaved formulas; a special electrically heated bottle warmer mounted on a traveling carriage completes the equipment of the room.

Stock formulas consisting of water, corn sirup and evaporated milk are prepared unsterile in bulk. These formulas are poured into previously washed nursery bottles which are then fitted with nipples and covered with protecting glass caps. The bottles thus prepared are then placed in special racks containing eight bottles and are autoclaved at 7 pounds' pressure for twenty minutes.

The units so sterilized are placed in the refrigerator until required when they are removed to the special bottle warmer which contains a feeding for each infant. This warmer is moved to the nursery and plugged into an electrical outlet which automatically brings the bottles to a temperature of 160° F. and then automatically lowers the temperature to 102° F. which is maintained indefinitely. A green light on the outside of the warmer indicates that the bottles have reached this potable temperature.

When the nurse feeds the baby she removes the bottle from the warmer but does not remove the glass cap until just before the nipple is presented to the baby, who thus nurses from a sterile and previously unexposed surface.

As an extra measure of safety the original isolation nursery has been retained with cubicles to hold four additional cribs. Provided with similar cubicles it has been so arranged that it will house four extra bassinets.

Based on the technics adopted at Massachusetts Memorial Hospital and at Sinai Hospital in Baltimore, the pediatrics and obstetrical staffs of Montefiore Hospital have agreed on the standard procedures below.

From the standpoint of public relations there is perhaps no department in the hospital concerning which it is easier to arouse community interest. The sum necessary completely to remodel the obstetrical building at Sinai Hospital was the gift of a philanthropic citizen who gave generously in the interest of better maternal and infant health, while at Montefiore Hospital the Ladies' Hospital Aid Society raised at a luncheon the $10,000 necessary to accomplish the physical improvements described.

NURSERY TECHNIC

Aims

1. To ensure that each infant has its own carriage and supplies and receives all its care and treatment in its cubicle.

2. To ensure that nurses and others in the nursery (a) scrub hands thoroughly for five minutes upon entering the nursery; (b) wear mask, cap (completely covering the hair) and gown; (c) wash hands thoroughly before touching each infant, after contact with any infectious material or after contact with own face, mask or handkerchief; (d) keep nails short, clean and free from polish; (e) avoid wearing any jewelry.

3. To ensure that doctors wishing to examine any infant will do so on the examining table in nurses' station. Before receiving the infant they will: (a) scrub hands thoroughly; (b) put on cap, mask, gown. The infant will be placed on examining table in a carrying blanket.

Delivery Room Routine for Baby

Supplies:

1. Baby pack containing carrying blanket, shirt and two diapers.

2. Silver nitrate, 1 per cent, oil, Zeigler clamp and band.

Procedure:

Apply Zeigler clamp to cord. Place 4 by 4 inch sponge saturated with 70 per cent alcohol around clamp and apply band.

Take rectal temperature.

Credé eyes with 1 per cent silver nitrate.

Cleanse infant thoroughly with oil to remove all vernix and blood, wipe off excess oil.

Weigh infant.

Place name band on left wrist.

Take footprints.

Dress infant in shirt, diaper and wrap it in blanket and take it to the nursery.

Make out crib card.

Admission of Infant to Nursery

Check name with delivery room nurse and note sex. Note condition of infant.

Place infant in Trendelenburg position for twelve hours to aid the escape of mucus.

Watch closely for cyanosis and choking caused by mucus.

Aspirate a milk trachea if necessary.

Place crib card on the crib with following information: date, time of delivery, name and sex, room, doctor's name, birth weight.

Routine Daily Care of Infant

Supplies:

Daily oil bath.

Cotton, oil, applicator tips, two diapers, shirt, band, crib pad, sheets, blankets.

Procedure:

Wash hands. Undress baby in crib and place on bathing cushion.

Wash eyes with 4 per cent boric acid solution.

Cleanse nose.

Cleanse buttocks.

Take temperature.

Cleanse cord.

Place scale paper on scale, weigh the infant and record weight if four days old or over.

Work the infant completely with oil and wipe off excess.

Place in crib on back.

Clean up unit. Wash hands thoroughly before going to next infant.

Routine Care of Premature Infants and Those Weighing 5½ Pounds or Less

Weigh and bathe every other day.

Give 50 cc. of normal saline when necessary.

Formula: 6 ounces milk, 8 ounces water, 1 tablespoon dextrin and maltose. Offer 1 or 1½ ounces to infant every 3½ hours after the first twelve hours. Increase the amount as tolerated. Feed with medicine dropper or Breck feeder but try nipple first. Use breast milk if indicated.

Formula Room

Supplies:

Required sugar.

Milk (evaporated or homogenized).

Can opener.

Knife.

Measuring spoons.

Pans.

Several graduates.

Necessary bottles and rack.

Sterile caps and nipples.

Procedure:

1. Place necessary bottles in racks. Put name tags on racks.

2. Scrub hands and sink for three minutes.

3. Prepare formula in clean unsterile containers, with clean unsterile utensils, using running faucet water.

4. Fill clean bottles with formula.

5. Apply nipples and sterile caps.

6. Place bottles in bottle racks and then autoclave at 7 pounds' pressure for twenty minutes.

7. Remove from autoclave and place on table to cool.

8. Mark infant's name on bottle with marking pencil.

9. Separate bottles on tray, according to feeding, and store in refrigerator.

The Outlook on Interns and Residents

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WITH reconversion from the 9-9-9 program expected to be in full effect after April 1, hospital administrators and their medical staffs are moving closer to normal operations. All recognized the necessity for the 9-9-9 program, a war-time measure, as the only fair method of distributing the services of recent medical graduates between the armed forces and civilian hospitals. Much credit is due hospital directors and medical staffs for their willingness to make the program the success it was, in spite of the severe handicaps of fewer nurses and trained laboratory workers and increased hospital admissions.

Everywhere reconversion is an intricate, complex and difficult operation. Hospital administrators are well aware of the many problems facing them during this period. Most hospitals will not simply return to a prewar program. Questionnaires show that there are large numbers of recent medical graduates who want long periods of hospital training. Older medical officers have indicated they want some type of refresher training. Many young medical officers have indicated their desire to qualify for an American board certification. Thus, hospitals and medical schools have new burdens placed on them.

With discontinuance of the war-time program hospital administrators would do well to reassess objectively the type of training they are best equipped to provide. A number of institutions, such as Duke, Northwestern and Minnesota universities, have developed extramural residencies for returning veterans. These plans help to solve some of the housing problems that face the hospitals. Extension of the internship from nine to twelve months will place many hospitals in real difficulties in regard to housing the interns for an additional three month period. A few hospitals have explored the possibility of having the interns live outside the hospital for the last three months of their training. While this procedure will relieve the problem of finding suitable quarters for interns, it will bring some additional financial obligations to hospitals. It has also been suggested that interns work from 8 a.m. to 5 p.m. daily at the hospital except when they are on night duty.

Return of the twelve month internship will necessitate some expert reshuffling of training programs. Hospitals evolved satisfactory apportionment of the interns' time among the various services. During the transition period there will be some overlapping and unavoidable duplication of service. Neither of these presents too formidable a problem, but they will tend to reduce the effectiveness of training programs for returned medical officer veterans.

How to Fit Them In

A more serious obstacle will be fitting in the interns newly arrived from medical school and the "hold-over" intern, who will stay on for three extra months. Some hospitals habitually make their house staff appointments far in advance. A certain amount of readjustment of contracts and specific services for the new class of interns will be required to work these problems out.

Replacement of the present resident staff brings even greater difficulties. As presently organized, most hospitals place great reliance on the resident staff in the supervision of interns and the performance of routine procedures. Veteran medical officers are being appointed to fill these residencies so that hospitals will not be without an adequate resident staff after April 1 when present residents and assistant residents holding reserve commissions are called to active duty. The success of the hospital's reconversion from a resident staff composed of commissioned officers on a deferred status to returned veteran medical officers is an individual problem at each institution. At present, there are a large number of veteran medical officers who are eager for such appointment. In fact, the number is growing larger daily,

Added Word to Small Hospitals

INTERNS who begin their service April 1, 1946, are to be permitted to continue until July 1, 1947, thereby having fifteen months of service. Many of these men have been under a rigorous program for four years, and they might welcome a period of vacation between April 1 and July 1, 1946. By granting such a vacation, which it is understood will be acceptable to the Procurement and Assignment Service, the Army and the Navy (or by having interns enter the military service early) hospitals should be able to adjust their facilities and services to this phase of the program.

Insofar as residents and assistant residents are concerned, the only way these positions can be filled is by the appointment of returning medical officers who desire further training through such experience. The larger hospitals will no doubt have multiple applications for such training from veterans, but opportunities for such training in smaller hospitals may not readily be brought to the attention of returning veterans. Administrators of these hospitals might be well advised to keep the Council on Medical Education and Hospitals of the American Medical Association informed of such opportunities in their institutions. This channel, it appears to me, offers the best opportunity for hospitals to make the immediate reconversion adjustment.—ARTHUR C. BACHMEYER, M.D., *director, University of Chicago Clinics.*

and there are many highly competent men in the group.

Some hospitals have been reluctant to appoint men from this group since they feel they would rather utilize the younger graduate who has become accustomed to their ideas of management and their routines. It should be pointed out that this unfortunate attitude already has had serious repercussions among the veteran group. Under the new plan very few hospitals will be allowed to keep commissioned officers on a deferred status.

Wise hospital superintendents are already appointing veteran medical officers or residents. Such appointments are not counted against current residency quotas and allow the veteran to become acquainted with the management of the hospital. After April 1, when these hospitals will lose their residents on a deferred status, they will suffer little disturbance in their house staff efficiency.

The appointment of veteran medical officers should be undertaken at once in every case so that the hospital will be in the most advantageous position possible in regard to future operations. Appointments should be carefully made, and the selection should follow as closely as possible the past patterns of the institution. Veterans are not to be selected merely because they have rendered service to the nation; rather, appointments should be made on the basis of past performance and promise of future attainment.

Readjustment May Be Hard

The earlier such appointments are made, the more likely it is that the changeover can be accomplished without disrupting service. It is not unlikely that some veteran medical officers will find it difficult at first to adjust to civilian medical life. How rapidly the veteran will be a real replacement for the present resident staff member will depend on the man, the attitude of the hospital staff and the replaced resident.

Hospital superintendents can do much to make the replacement more satisfactory by having informal conferences with the veteran and giving him encouragement. Some have found that assignment of veterans to older hospital staff members as preceptors is a highly successful way to speed the adjustment. It is important that veterans be assigned specific tasks in the hospital even during the transition period. Vague assignments or broad duties, such as "We will let you look about the hospital for a time," retard rather than hasten the veteran's reconversion as a civilian resident.

As the veteran learns more about the hospital, he should be given more and more responsibility. The ultimate success of reconversion from the war-time program will depend on the rapidity and efficiency with which veteran medical officers become effective residents. Unfortunately, some veterans will not be able to make the change. As soon as this is apparent, they should be consulted and helped to find the type of work they like and are capable of doing.

Hospital superintendents valiantly met the numerous changes thrust on them by the war. Now they are called on to work out a more complicated procedure during a less dramatic time. The early appointment of qualified veteran medical officers as residents, the thoughtful guidance of them during their early adjustments to civilian life, the assignment of progressively more important tasks and the encouragement of them in their hospital training will do much to make the reconversion program a success. It is a challenge to hospital staffs and a reward to the veteran for his war service.

It's *Their* Blue Cross

JAMES E. STUART
Executive Vice President, Hospital Care Corporation, Cincinnati

THIS is the case for subscriber representation in Blue Cross plan management. Who has a better right to a voice in Blue Cross program and policy making than the folks who put up the money?

The idea of subscriber representation apparently originated in Cincinnati with the formation of Hospital Care Corporation in 1939. The original code of regulations and by-laws provided that, in addition to a majority representation by the participating hospitals and certain representatives from the professional groups and general public, the chairman of the subscribers' council would be a member of the board.

The original idea was that the subscribers' council should be composed of a representative of each enrolled group and that this council would meet from time to time and consider all phases of the Blue Cross program that related directly to the subscriber. The rapid growth of the plan, however, made the subscribers' council too large a group for proper discussion and consideration of such matters. Therefore, by action of the board and approval of the council, the council was subdivided into area subscribers' committees, with one committee for each of the major population areas in the 14 counties of southwestern Ohio served by Hospital Care Corporation.

It was proposed that the over-all subscribers' council should meet once a year and these annual meetings of the council were held until the second year of the war; then, by agreement, they were discontinued until after the war emergency. During these war years, the subscribers' council functioned by annually electing by mail a chairman who is a member of the board of trustees of the corporation.

Local Committees Are Active

The local committees, however, functioned actively throughout the period, meeting at least semiannually and more often when necessary. At these meetings the local committees are brought up to date on the progress of the Blue Cross plan and all matters of policy relating to the program of making Blue Cross available to the people of southwestern Ohio are fully considered, with recommendations made to the board of trustees through the chairman of the council. No change in benefits, rate structure or general policy (except in

relationships with hospitals) is made by the board of trustees without first studying recommendations from the subscribers' committees and, to date, no such change has been made unless it has been recommended by these committees.

As an example, in 1943, when the board felt that the Blue Cross plan coverage should be extended to include all items that normally appear on a hospital bill, including all types of special drugs, serums and x-ray, without money limitations, for which an increased fee would have to be charged, the whole matter was referred to the subscribers' committees for consideration and approval before any public statement was made in regard to the proposed changes. The subscribers' committees after full consideration felt that the additional benefits should be added to the subscriber's contract and that the subscribers should be asked to pay the additional amount suggested.

Results Justified Action

When the changes were announced to the member groups and the general public, it was carefully explained that these changes were made on the recommendation of the subscribers' committees. It was originally contemplated that any increase in rates might cause some loss in membership, but the net result of the change in benefits and rate structure was that the Blue Cross plan had its largest monthly growth in its history during the month when the change was effected.

The value of subscriber representation is not limited solely to its function of giving the subscriber a voice in program and policy making. Such a device assists the local director by serving as a sounding board on which contemplated changes can be tested and by keeping him and his staff in close touch with the public opinion of the community. It is also of inestimable value in promoting Blue Cross enrollment and in achieving complete acceptance of the local plan as the nonprofit community method of providing protection against the cost of hospitalized illness and accidents.

For those who doubt that such results will follow subscriber representation and participation in the program and policy making of a Blue Cross plan, the record in Cincinnati should be convincing. Out of a total population of 1,250,000, in five years Hospital Care Corporation by working closely with the subscriber, as well as with management, labor and participating hospitals, enrolled more than half a million members. In several communities, more than half the total population has been enrolled solely through employed groups.

Local subscribers' committees have been in close touch with the national program of Blue Cross which has been presented from time to time and thoroughly discussed by these representatives of the subscribers. Take, for example, national reciprocity of Blue Cross benefits. More than two years ago, the Middletown subscribers' committee began asking why its members couldn't receive Blue Cross service benefits from local plans when they were hospitalized away from home.

The members wondered why, since we had a national Blue Cross plan commission and since Blue Cross plans were sponsored and approved by the American Hospital Association, membership in one plan could not be, in effect, membership in all Blue Cross plans. National reciprocity of service benefits now is provided by some 33 Blue Cross plans and the goal which our subscribers' committees originally approved on the initiative of the Middletown committee seems to be within sight of achievement.

In the field of public relations generally, these committees have carried a large part of the responsibility of the local Blue Cross plan. Members of the committees have opened the doors of unenrolled groups to Blue Cross membership and greatly facilitated contacts with local newspapers, radio stations and other mediums of public education and free publicity. The problem of adequate publicity and public education was to a large extent solved by the activity of the local committees.

The basic strength of any community organization may be measured by the degree of its acceptance by the general public and the extent to which the community participates in its plans and programs. No organization could propose to do a job for all the community—in health, social service or in any other phase of civic activity—with hope for success without such participation and support unless it is a compulsory tax-supported program.

The committee on subscriber relations of the Hospital Service Plan Commission has formulated plans for the organization of effective subscribers' committees in Blue Cross plans of all types and sizes, based on the Cincinnati experience. In summary, its recommendations would provide through an amendment to the by-laws of the Hospital Service Plan that:

1. A subscribers' committee shall be organized in each metropolitan or major population area served by the plan, membership to be appointed from group leaders in the area which the committee serves.

2. A subscribers' council shall be organized, representing the total plan area. Membership shall consist of (a) chairmen of the local subscribers' committees; (b) other persons to bring the total membership to not more than 100, to be appointed initially by the plan president and thereafter to be elected by the group leaders of the enrolled firms. (For the larger plans the council might be limited to group leaders with 50 or more enrolled subscribers and the local committees might be limited to 12 or 15 members elected by all the local group representatives.)

3. The chairmen of the subscribers' committees shall serve on the executive committee of the subscribers' council.

4. The chairman of the subscribers' council shall sit as an ex-officio member of the plan's board of trustees.

5. The president or plan director shall designate a member of the staff who shall serve as secretary of the council.

Plan Should Pay Costs

Experience has shown that there should be two or four meetings of the subscribers' committees and one meeting of the council each year. It is preferable to meet at luncheon or dinner with the plan standing the expense of such meetings. This expenditure has been proved well justified on the basis of results obtained.

Meetings of the local subscribers' committees should precede the meeting of the council. At these meetings, the plan director or a designated staff member should present

a progress report on enrollment, finance, public relations and any contemplated changes in procedures or program for discussion by the group.

The members should be given a chance to present their problems and complaints, thereby affording an excellent opportunity for correcting on the spot local difficulties regarding subscribers or subscriber groups. The committee should at all times feel that it has, as it should have, a definite responsibility for the success of the plan, with a definite part in planning and promoting its activity.

Representation of the subscribers on the board of trustees makes their participation official and fully recognized but the committee must know that the representative on the board speaks for it and for all subscribers as it has recommended. When the board of trustees gives due consideration to their recommendations, the subscribers can feel that Blue Cross is their plan and they have a part in its program and its success.

We must recognize and foster democratic principles in the organization and functioning of Blue Cross if it is to become and remain a truly nonprofit community service. The organization of subscribers' committees offers a method of accomplishing this end. After all, it *is* their Blue Cross plan.

When the Needle Breaks

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WHILE hypodermic needles do not often break during a procedure, such accidents do sometimes occur. In a study made by one hospital of the causes of needle breakage during lumbar punctures and hypodermoclyses, an examination of the broken pieces revealed that there were varying degrees of corrosion of the metal on the inside of the cannula at the point of breakage.

It was found that all the needles were made of high carbon steel, but that in manufacturing the needles the inside remained untreated while the outside of the cannula was plated with rust-resisting nickel.

Stainless Steel Needles Used

A change was made to stainless steel needles for procedures such as lumbar punctures, local anesthesia and hypodermoclyses, with the result that the danger of breakage has been reduced to a minimum.[1]

Yet when a needle does break, the question may arise as to who is legally responsible for the resulting injury to the patient.

It is an established principle of law that the operating surgeon is liable for the negligence of hospital employes while they are actually assisting him in the operating room. But when employes of the hospital are negligent in carrying out the surgeon's instructions as to treatment after the operation, the surgeon is not liable if it cannot be shown that he was negligent in giving the instructions or in selecting the persons to carry them out; that he was present and could have avoided the injury by exercising due care, or that his special contract relative to the negligent employe was such as to make the doctrine of *respondeat superior* (responsibility of employer for acts of employes) applicable.

The mere fact that the surgeon gives the instructions, or even specially designates the particular employe who is to carry out the instructions, does not give rise to a master-servant relationship.

Part of the service furnished by the hospital is the assistance of nurses, interns and attendants in caring for the patient after the operation pursuant to the instructions given by the operating surgeon. They perform the duty required by the hospital, which is their employer, to the patient when they carry out the instructions of the doctor.

An operation for gallbladder disability was performed on a patient at one hospital. Immediately following the operation she was removed to the room which she had engaged. Since she had lost a considerable amount of body fluid during the operation, the operating surgeon instructed an intern to administer a hypodermoclysis, consisting of a saline and glucose solution. This the intern proceeded to do while the patient was still unconscious from the anesthetic and after the surgeon had left.

The equipment for the hypodermoclysis was furnished by the hospital and was brought in by a nurse. While the intern was inserting the needles in the patient's sides under the armpits, the needle on the right side broke off at the hub, leaving a segment 2 inches in length in the subcutaneous tissues. He tried to withdraw the broken needle but was unable to do so and called a resident physician who made several unsuccessful attempts to retrieve the needle. The attending physician was called and he decided to allow the needle to remain temporarily.

During the next six weeks the patient felt pain in her right side at various times. The operating surgeon then informed her that the needle had been broken off in her right side and that it should be removed. She immediately consulted another doctor who advised her that the needle should be removed.

Needle Was Rusting

There was evidence to show that the needle was rusting when removed. The intern testified that he had examined the hub carefully and that it appeared to be a "little blackish" or rusty inside, leading him to conclude that it was latently defective. It was also shown that it was part of the normal duties of interns at the hospital to give hypodermoclyses after operations; that it was not the sort of thing which the operating surgeon must do himself, or that it was not customary to have interns do it. The physician had not

[1] Prager, J., M.D., The Broken Hypodermic Needle, Mod. Hosp. 53:53 (July) 1939.

contracted, expressly or impliedly, to perform it himself.

Such being the proof, the court held that the patient could not recover from the doctor. The physician in giving instructions to the intern did not alter the master-servant relationship between the hospital and the intern and did not create an employment contract or relation between the surgeon and the intern. The fact that the surgeon's instructions related to a "medical measure" rather than to "usual nursing measures" did not in itself create an employment situation.

Neither the mere leaving of the needle in the patient's body under the circumstances nor the length of time which elapsed before the surgeon informed the patient of its presence and removed it was negligence as a matter of law. The decision to allow the needle to remain until the patient's strength was recovered sufficiently to withstand the physical and psychological effects of the removal was proper, if not essential to preventing serious impediments to recovery.[2]

Liability for Acts of Others

When one physician, acting in concert with another in the performance of an operation, perpetrates an act of malpractice, the other may be held liable for the acts of the wrongdoer if he observes such wrongful conduct and lets it continue without objection or if he fails to observe and act upon that which, in the exercise of ordinary care and diligence under the circumstances, he should have observed and acted upon.

According to the facts in one malpractice action, the surgeon engaged by the patient to perform a major operation in turn engaged a medical anesthetist to administer a spinal anesthetic preparatory to the operation. In the absence of the surgeon, the anesthetist prepared the patient for the anesthetic; while he was forcing a hollow needle, with stiletto and plunger attached, into the back of the patient between the third and fourth lumbar vertebrae to inject novocaine, the needle broke.

Thereupon the surgeon entered the operating room and, after being informed of the accident by the anesthetist, obtained another needle, administered a spinal anesthetic and proceeded to operate upon the patient's abdomen.

Nine days later, when the patient had recovered sufficiently from the abdominal operation to leave the hospital, she was informed by the surgeon that it would be necessary for her to submit to another operation for the removal of the broken needle. He removed the broken needle, after some difficulty in determining its exact location. As a result of the imbedded needle and the necessary operation for its removal, the patient suffered severe physical consequences.

At the trial no competent evidence was produced by the patient of the failure of the surgeon properly to perform the operation for the removal of the broken needle or that it was improper practice to allow the broken needle to remain in the patient's body until such time as the patient had sufficiently recovered from the abdominal operation to withstand a second operation. Nor was there any proof upon the subject of what is proper practice and custom to be followed by a surgeon in charge of an operation during the administering of an anesthetic to the patient by another surgeon employed as an anesthetist.

The court held there was no liability on the part of the surgeon, but that the medical anesthetist could be held responsible. The arrangement was for the surgeon to perform the abdominal operation and for the anesthetist to administer the anesthetic and although the surgeon engaged the anesthetist, nevertheless, by implication, there was created a separate contract between the patient and the anesthetist. Under these circumstances each doctor was engaged to perform his separate and distinct work independent of the other.

The surgeon was not negligent in his selection of the anesthetist, nor did it appear to be the practice and custom in the community for the surgeon to be present or to assist the anesthetist in the operating room while the patient was being anesthetized. No acts were performed in concert with the anesthetist for which the surgeon might be held liable. It was for the jury to decide upon the anesthetist's negligence.

"This court is of the opinion that, while the breaking of the needle in the instant case does not permit the application of the rule of evidence known as *res ipsa loquitur* (the fact speaks for itself), nevertheless, the breaking of the needle under the circumstances, coupled with its location outside of the channel of soft tissues and against the bone, as shown by the x-ray film, gives rise to a *prima facie* case of negligence sufficient to call upon the defendant Michaels for explanation. And while it may be that the anesthetist followed approved custom in his attempt to administer the anesthetic, nevertheless, custom alone, as hereinbefore set forth, will not exonerate one from a charge of negligence."[3]

It is well established that the master and servant relationship does not exist between the hospital and the physician who treats the patient; the doctrine of *respondeat superior* applies only to the acts of a servant who serves under the direction and control of the employer. A professional man acting upon his initiative and without the direction of others is an independent contractor.[4]

The intern is a professional man in the same sense as the physician; both practice medicine in the hospital, although the intern usually does so under the supervision or direction of the attending physician.[5] As a general rule of law, the operating surgeon is not liable for the negligence of interns in hospitals.

Surgeon Relies on Intern

In the after-treatment of the patient it is customary for the operating surgeons to rely on interns unless the surgeon specially undertakes such employment.[6] Unless the surgeon or physician controls or supervises the care of the patient, he is not liable for the careless acts of the intern. In other words, at the time the intern is acting under the surgeon's immediate direction, the surgeon assumes responsibility for the intern's acts.[7]

As for the hospital, it would not be responsible for any negligence on the part of the intern in the use of the instrument unless it could be shown that the hospital authorities knew or ought to have known of his incompetence.[8]

[2]Hohenthal *v.* Smith, 114 F. 2d 494 (App. D. C.).

[3]Wiley *v.* Wharton, 41 N. E. 2d 255, 68 Ohio App. 435.

[4]Norton *v.* Hefner, 132 Ark. 18, 198 S. W. 97.

[5]Nickley *v.* Skemp, 239 N. W. 426 (Wis.).

[6]Hunner *v.* Stevenson, 122 Md. 40, 89 A. 418.

[7]Stanley *v.* Schumpert, 117 La. 255, 41 So. 565.

[8]Roewekamp *v.* New York Post Graduate Medical School and Hospital, 283 N. Y. 35, 27 N. E. 2d 442.

A monument to patience is the out-patient department of any large hospital where the ambulatory sick wait, sometimes for many hours, to see the doctor.

Salem Hospital, Salem, Mass. Photograph by William Rittase

The Dilemma of Medical Social Work

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THE hospital is a complex and highly organized agency in which there are people professionally equipped to diagnose and relieve bodily ailments. It is composed of a bewildering number of doctors, technicians, nurses, maids, clerks and orderlies, working together with diverse functions and specialties, interlocking and interweaving for the one end of treating disease. It is a mysterious and rather fearful place to the layman. The following is a possible and not uncommon kind of experience within this setting:

A patient comes with a sore on his foot which refuses to heal and for which he expects to have a little antiseptic and a small bandage. He will be directed to the admitting office, where he sits for perhaps half an hour, waiting his turn. During this time he may see several accident cases brought in and will observe the others waiting with him who have more or less outward evidence of disease.

The Interviewing Starts

Eventually he is seen by a nurse and then a physician to whom he gives the details of his injury and past health; the sore on the foot is examined and he is told to register for the surgical clinic. He then sees an admitting clerk who questions him about rent, wages, savings, insurance, makeup of family, nationality, religion, home address and name of employer. A fee is assessed, which may be more or less than he can afford.

He waits in line, first, for an appointment for the surgical clinic and, again, to pay for a ticket to the clinic. There he may wait two or three hours until the clinic opens. Reporting to the clinic, he again gives name, address and other identifying data to the secretary and waits for perhaps one or two hours until his turn comes and he is taken into an examining room by a nurse who instructs him to undress partially and who later returns to prepare him for examination.

Eventually a doctor in a short white coat comes in and takes a medical history, including all his past illnesses, starting with early childhood, inquires into the illnesses of his family and also asks for considerable information about his occupation, dietary habits, family life and home surroundings. Presently another doctor comes in in a short white coat, examines his foot, listens to his heart and lungs, takes his blood pressure and perhaps makes an even more extensive examination.

After a time a third doctor comes in a long white coat. To this doctor, the one who has taken the history and the one who has examined him report what they have found. Some of it sounds familiar, some very strange and impressive. It is apparent that they are deliberately using words that he cannot understand. The doctor in the long coat asks him a few questions, discusses with the two others something about sending him here and there and something about dressing his foot; then he leaves.

At Last, the Bandage

Finally, some ointment and a bandage are applied. He is told about applications to be given at home, advised not to walk any more than necessary and told that he should return the following day for

The early part of this paper is an excerpt from an article from the Journal of Social Work Process 1, November 1937, published by the Pennsylvania School of Social Work.

examination in the medical clinic.

The next morning the business of waiting, giving of history, examination (this time more extensive) is repeated. Again there are two new short-coated doctors and a long-coated one. The whole process takes three or four hours.

When he leaves one of the doctors gives him slips and the secretary at the desk explains that he is to return to this clinic in a week. In the meantime he must have some tests made. These include giving in the laboratory a sample of urine, a drop of blood from his finger and about a tablespoon of blood from his arm. These all cost money, in accordance with the fee agreed upon the day before. He may also be asked to have other examinations, including an x-ray plate of his chest and an electrocardiogram, which are still more costly. These require special appointments and can probably not be done on the same day.

There are the registration at each place, the tickets and new people whom he has never seen before. He returns to the clinic at the end of the week. He is seen by the three doctors again. They may murmur something about sugar in the urine, old healed acid-fast lesion, arteriosclerotic changes, slightly positive Wassermann. He is referred for consultation to the diabetic, syphilis, tuberculosis and cardiac clinics, for all of which special appointments have to be made and he is told to return in two weeks when the reports of these examinations will be back.

May Mean Real Trouble

It may be and often is true that a person coming into the clinic with what appears to be a minor and slightly troublesome complaint, such as an unhealing lesion on the foot, may be found to have such a syndrome of diseases as diabetes, syphilis, tuberculosis and the arterial and heart changes so often accompanying them.

It is also true that a person having any one of these diseases may have been unaware of its presence for years or have ignored the slight symtoms it gave in the course of a busy and satisfying life.

Yet we know that if they continue untreated this person may in the course of a comparatively short time become hopelessly disabled. The unhealing sore may spread until amputation is necessary, the old tuberculosis lesion may become active, the heart and arteries may lose their power to function, the kidneys may wear out under the load of unused waste products they have to handle and many other disabling changes may occur.

The story of this patient's experience, lifted from a paper on social case work in a medical setting, paints a grim and rather hopeless picture. As a matter of fact, many teaching hospitals do serve patients well.

Much of this procedure is necessary if patients are to have the maximum benefit from a large, well-equipped medical center. Its more overwhelming aspects can be mitigated, however, if the administration feels imaginative concern about the meaning of the experience to the patient.

Process Can Be Speeded Up

Administrative devices can help a great deal, such as efficient and speedy clerical, filing and messenger service; effective unit record systems; the holding of a professional staff to a reasonable appointment system; the breaking down of large, unwieldy and, therefore, irresponsible departments into small, self-contained responsible units; the provision of pleasant informal waiting rooms equipped with recreational materials and of secluded and private space for the exchange of confidential information between the patient and staff member. All of these devices can increase the effectiveness of the hospital in serving patients well.

The most costly and ingenious systems break down, however, unless the hospital as a whole has a motivating philosophy of service. A superintendent who is convinced that every patient is a potential chiseler; a medical chief who feels annoyance with the "old crocks" and with routine diseases that may crowd out rare clinical material; the supervisor of nurses who resents the upsetting of routines by a troubled or "uncooperative" patient, all affect profoundly the corporate personality that the patient feels in the hospital.

Clinic and hospital staffs, particularly the young people who are there to learn an unfamiliar field, find hospitals overwhelming and frightening too. Callow flippancy, a good story that belittles a patient, a brusqueness or an air of detached, uncommunicative coldness are protection against the responsibilities of their new jobs and the suffering they shrink from. These young people need help in learning how to work with people if they are to be successful assistants in healing.

Supervision needs to be focused on the problems of the patient inherent in the large hospital setting. Staff participation in planning good administrative procedures to help the patient on his way through the complexities of the hospital takes time, thought and supervisory skill but from it the staff will learn the unconscious courtesies, the need of simple words of explanation and direction that will help the patient to feel that he is a participant rather than a specimen.

In this time of shortage in the professional case work field it is inopportune to urge an extension of medical social work. Oversentimental, protective muddling in people's lives so likely to come from untrained people thrown into the hospital setting to "give social service" can add to the patient's problems.

Good Case Work Helps

On the other hand, there are few settings in which the specialized technical skills developed by professional social work have greater value. It is not easy to help people to find a new balance and to reorganize their lives when illness makes major changes in their modes of living desirable, nor is it easy for patients to utilize to the full the complex services of modern medicine intelligently. Good case work readily available to patients at those moments in a hospital experience when major decisions need to be made by them can greatly increase the treatment value of a hospital.

Some of the key points for case work are: admission to clinic or hospital; convalescent discharge; the beginning of a long series of treatments; the giving of a serious diagnosis by the physician, and the need to buy costly equipment.

The answer to the problem of treatment in a teaching hospital does not, however, rest on any one service but on the total integration of a hospital into an organization motivated in all its parts by a basic desire to help sick people get well. This is hospital administration.

hospitals are concerned with new developments in

Venereal Disease Control

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HOSPITALS and physicians in private practice are playing increasingly important rôles in the control of venereal disease. The success of one, two and three injection penicillin treatments for gonorrhea is returning the management of gonorrhea to the private physician on an out-patient basis and the intensive in-patient treatment of syphilis has made hospitals an important element in syphilis control.

These developments in venereal disease control are a result of experience gained during the war-time venereal disease program. The termination of war has not terminated the venereal disease control program. The movement of members of the armed forces from the theaters of war to separation centers and then to their home communities and the geographic reshuffling of war production workers present venereal disease potentialities quite similar in character to and not less in magnitude than those characteristic of the war period.

Greater Danger of Infection

The return to the population of millions of young men and women in the age groups in which venereal disease occurs most frequently, no longer subject to the highly organized educational and control measures of the armed forces, greatly enlarges in itself the mathematical possibility of new infections among civilians. However, experience gained during the war already is proving to be of utmost value in the postwar control of venereal disease.

Of major importance are the special hospitals, known as rapid treatment centers, for the intensive treatment of the venereal diseases. These centers were established as a war-time expedient, but they will be retained as a part of the postwar control program. Although a few of these centers were federally operated at the request of state departments of health, it is hoped that soon all these centers will be directly under the administration of state health officials. In addition, rapid treatment centers will be supplemented by special wards and beds in hundreds of general hospitals in areas not having rapid treatment centers, so that intensive treatment facilities will be more widely available.

Until recently the nationwide system of these special hospitals provided virtually the only available facilities for intensive in-patient treatment of syphilis. The rapid treatment centers were operated during the war primarily to isolate and render noninfectious, as quickly as possible, persons allegedly responsible for the spread of venereal disease among the armed forces and war workers.

During three years up to July 3, 1945, the Federal Works Agency, utilizing appropriations authorized by the Lanham Act, supplied funds to state and local health departments and other official agencies for operation and maintenance of the rapid treatment centers. During this period, 63 individual centers in 35 states, Puerto Rico and the Virgin Islands were subsidized by Lanham Act funds, and 10 additional centers were maintained and operated for seven states by the U. S. Public Health Service.

From the beginning of the program to July 1945, rapid treatment centers reporting to the Venereal Disease Division had admitted approximately 160,000 patients. At the beginning of the fiscal year, patients were being admitted to 54 reporting centers at the rate of 180,000 a year, almost a quarter of the number of venereal disease cases reported annually in the United States. About 36 per cent of the patients being admitted to the centers were white; 64 per cent, nonwhite; 38 per cent, male, and 62 per cent, female.

Only about 1 per cent of the patients being treated were infected with venereal diseases other than syphilis and gonorrhea. About 61 per cent of the patients being treated were infected with syphilis alone; about 39 per cent, with gonorrhea alone, and 9 per cent, with both syphilis and gonorrhea.

Average Stay Was Eleven Days

Throughout the three year period of operation, various schedules embodying the principles of the best of new intensive treatments for syphilis and gonorrhea were tested at the centers. Hospitalization made it possible to complete intensive treatment of selected cases of syphilis in an average patient stay of eleven days. Meanwhile, development of short schedules for treating gonorrhea with penicillin in from a few minutes to four hours largely removed the treatment of gonorrhea from the centers and is returning the control of this disease to private physicians and out-patient clinics.

As a consequence of these trends, the proportion of gonorrhea cases treated in rapid treatment centers has been reduced and the proportion of infectious or potentially infectious syphilis cases treated in the centers has increased. The cost of treating

patients in the centers was reduced by 56 per cent for syphilis and 84 per cent for gonorrhea, reductions of from $119 to $52 per patient stay for syphilis and from $84 to $13 for gonorrhea. The average time required for treatment was reduced from twenty-four days to eleven days for syphilis and from sixteen days to two days for gonorrhea, reductions of 54 per cent and 88 per cent, respectively.

Experience gained in the operation of these centers made it apparent that the quick and safe treatment of syphilis afforded by in-patient care was an important contribution to the general control program and that ideally such care should be available to all persons with syphilis in an infectious stage. Hospitalization of the syphilis patient makes possible administration of drugs every three hours, day and night, to complete treatment within nine days. This greatly reduces the difficult case-holding program with which public clinics were obliged to contend when all syphilis patients were treated with the course of 30 injections of an arsenical and 40 injections of bismuth administered over a period of seventy weeks.

It has been estimated that formerly only 25 per cent of all syphilis patients completed the seventy weeks of treatment whereas under the intensive treatment method nearly 100 per cent of all syphilis patients complete the required amount of treatment.

U.S.P.H.S. Has Responsibility

Recognizing the evolution of the program from a war facility to what should logically be a general treatment facility for all patients subject to public care, Congress in July placed in the hands of the U. S. Public Health Service the responsibility for administration of the centers as a part of the nationwide venereal disease control program. Five million dollars was appropriated for use in the fiscal year 1946 to subsidize the maintenance and operation of existing centers, for the establishment of new centers as required and for the payment of fees to hospitals for providing in-patient care for venereal disease patients.

Contract proposals for 52 individual centers in 31 states were approved by the Public Health Service from July 1 to Oct. 1, 1945. Of the total number of rapid treatment centers, 42 are state operated; 33 of these are special hospitals exclusively for the treatment of venereal disease, and nine are special wings or wards rented in general hospitals providing complete intensive treatment facilities. The other 10 centers are operated for the states by the Public Health Service; nine of these are special hospitals and one is a bed rental facility in a city hospital for communicable diseases.

By Oct. 1, 1945, bed rental contracts had been made with more than 300 general hospitals in 10 states. Hospital bed rental contract proposals, made by state departments of health, arose from the need for treatment facilities for venereal disease in areas in which there were no rapid treatment hospitals. The bed rental contracts provide for the rental in general hospitals of as many beds as are needed within the area for the intensive treatment of patients with venereal disease and for supervision of treatment by state departments of health.

One of the requirements to be met by hospitals before approval of contracts is that no more than $7.50 a day shall be charged for patient care; $5 of this amount is paid by the U. S. Public Health Service and $2.50 from state or local funds. This amount must cover all expenses of the patient, room, board and care, during hospitalization.

The number of beds rented in general hospitals varies according to the sizes of the hospitals and the needs within the various areas. A complete wing, a ward or only five beds may be rented. In New York City under one contract an average of 118 to 120 beds a day is rented; at a hospital in San Diego, Calif., the average rental is 13 beds a day. Only the beds actually used in a day are paid for through the contract arrangement, which is similar to that employed in the Emergency Maternal and Infant Care program administered through the Children's Bureau of the Department of Labor.

Altogether, the rapid treatment hospitals, special wards and the rented beds form a network which could provide in-patient facilities for the intensive treatment of all cases of infectious syphilis reported each year. Of the 182,000 infectious or potentially infectious cases of syphilis reported during 1945, 52,000 were treated at rapid treatment centers and the remaining 130,000 were treated elsewhere; an increasing proportion of these cases undoubtedly will be treated in rapid treatment facilities in the future.

Venereal disease control statistics for the fiscal year 1945 show the growth in importance of rapid treatment centers.

The 373,288 cases of syphilis and the 301,828 cases of gonorrhea reported, by all sources, for the first time to state health departments during the year represented 21 per cent and 3 per cent decreases, respectively, compared with cases reported in 1944. Rapid treatment centers admitted 61,898 cases of syphilis and 67,326 cases of gonorrhea, increases of 407 per cent and 318 per cent, respectively. Clinic admissions for syphilis were 278,369, a decrease of 22 per cent; clinics admitted 200,176 gonorrhea cases, 36 per cent more than were admitted in 1944.

The number of cases of primary and secondary syphilis reported was 78,015; the number admitted to rapid treatment centers was 22,985, and the number admitted to clinics was 51,631; the number of early latent cases reported for the first time was 104,752; the number admitted to rapid treatment centers was 29,825, and the number admitted to clinics was 98,438. (Cases reported to state health departments are cases reported for the first time. Clinic and rapid treatment center admissions include cases which may have been reported previously. Clinic admissions include rapid treatment center admissions.)

The number of clinics receiving federal, state and local financial assistance during the year was 3477, or 155 fewer than in the previous year.

Offers Method of Case Finding

Development of methods whereby treatment of gonorrhea with penicillin, administered in the physician's office, can be completed in a few hours should increase the interest and active participation of the entire medical profession in the campaign against gonorrhea; incidentally, it should provide a valuable syphilis case-finding aid since many gonorrhea patients or their contacts are infected also with syphilis.

The public clinic of the future probably will be concerned more largely with treating gonorrhea among indigents and with the diag-

nosis of syphilis for referral to rapid treatment facilities.

Because the intensive treatment of syphilis and the short treatment of gonorrhea have reduced the enormous case-holding problem of the past, more of the efforts of venereal disease control workers can now be directed to case finding and public education.

The hospital, also, could easily be a potent aid in case finding. If tests for syphilis could be made routinely on the approximately 15,000,000 patients admitted annually to hospitals, many thousands of infectious venereal disease cases, which otherwise would be overlooked, could be discovered without too much effort. No tests for syphilis could be conducted as readily as can the chest x-ray examinations made routinely of persons admitted to hospitals that are cooperating with the tuberculosis control program. The hospitals which for a number of years have been taking routine tests for syphilis on all admissions can undoubtedly substantiate the value of this method of case finding.

Efficiency and Economy should determine nursing needs

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THE number of nurses necessary to care for a given group of patients efficiently and economically has always been a question of prime importance to hospital administrators. To the patient also, expecting the best in nursing care, this is an important issue especially since it is the tendency in many hospitals to expect the nurse to do far more than she can possibly do well. The administration, while interested in satisfying the patients, is also vitally concerned with the economic aspects involved.

A study of actual existing conditions should precede the creation of a time standard in any hospital.

In making a time survey it is the aim to determine the numbers and status of the personnel required to carry out a definite daily routine on a definite number of patients.

It is by no means satisfactory merely to provide adequate nursing service for a twenty-four hour period; every part of the day should be considered.

All the factors influencing the bedside care in a given situation should be considered before making a time analysis. After this has been done a standard may be decided upon in the following manner.

1. By experiment find the average length of time required to carry out certain procedures.
2. By use of a daily routine find the number of times these activities are performed per day.
3. Multiply the average time for that activity by the number of times it is performed in one day to obtain the total time required per patient per day for that particular activity.
4. Multiply this figure by the number of patients to obtain the total time per day for that activity.
5. Make this estimate for all activities in twenty-four hours, add the totals to obtain the total amount of time spent for all patients in one day.
6. Divide this figure by 8½ to determine the number of nurses necessary to perform these duties.

Studies of this type are invaluable from the points of view of providing the best nursing care for patients, providing for maximum efficiency, ensuring general economy and providing a graphic picture of just when peak loads occur throughout the day. I made such a study at Albany in 1941; while nursing conditions changed radically in the intervening war years, the general principles and procedures outlined are still basically useful in determining the nursing requirements.

Mosher Memorial, the psychiatric division of Albany Hospital, Albany, N. Y., was the first psychiatric ward to be established in a general hospital in the United States. It occupies a two story wing separated from the main buildings. On the first floor are housed the female patients and on the second, the male. The division has a 36 bed capacity with a variable occupancy, the average being 15 women and 13 men.

Types of cases admitted include any of those found in the new classification of mental disorders adopted by the council of the American Psychiatric Association.

The length of hospitalization is short. The average stay in the hospital is slightly over two weeks. Because many diagnostic, consultant and treatment facilities essential to the welfare of the patient are available, individual treatment is accorded under the most favorable circumstances. Patients who show no improvement after thirty days are transferred to other hospitals for longer term treatments.

Psychotherapy is augmented by such modern treatments as anoxemia, insulin shock therapy, metrazol and erythroidin convulsive therapy, elec-

This paper was prepared while the author was a postgraduate student at Russell Sage College of Nursing, Albany, N. Y.

tro-convulsive therapy and x-ray therapy.

Mosher Memorial is a progressive institution and the work in research carried out by the psychiatrists and research department has a great influence on the amount of nursing service required. The use of certain drugs, for instance, may necessitate accurate observation and recording of the pulse, respiration and blood pressure of a patient every fifteen minutes for two hours after administration.

The next step in the creation of a time standard is a general consideration of the factors influencing bedside requirements.

Floor Plan Is Important

The construction and plan of the floor itself are of basic importance. At Mosher Memorial one does not find white walls lined with beds on either side. Instead, there are attractive and comfortable new maple furniture of early American design, walls tinted in restful colors, bright chintz, gay window curtains and cozy living rooms, and these present more the appearance of an attractive club than of an institution for the mentally ill. Construction plans favored appearance and atmosphere more than efficiency and time-saving devices.

All doors except those to patients' rooms are locked on this division. This locking and unlocking of doors is a great consumer of time even though it may take only a few seconds to unlock a door. When one considers that each nurse does this act hundreds of times in a day the seconds mount rapidly.

Arrangement of working facilities must also receive consideration. The fact that no equipment or linen of any kind may be kept in the patient's room is a time consumer. Poor arrangement of the medicine closet and inadequate utility rooms consume much unnecessary time and energy. Plans have been drawn up that will obviate this problem.

Provision of supplies and equipment is adequate in most cases and does not constitute a problem in planning nursing service. The frequency with which procedures are performed directly influences the nursing requirements.

Let us now look at the nature of the staff as it influences the nursing requirements. For the greater part of the year the staffing is on the part graduate, part student basis. Students do not replace graduate nurses one to one and thus nursing requirements are increased. The student's practice time is also broken by class time, which constitutes approximately ten hours a week. The same situation exists in regard to post-graduate students who work only a thirty-eight hour week.

The problem of class hours exists also for graduate staff nurses and subsidiary workers as well. A graduate staff nurse is given time allowance for any outside classes which she attends. Three of our staff nurses are at present taking two hours of classes per week. This means a total allowance of six hours a week for classes.

A well-planned educational program for subsidiary workers takes one hour per week per worker. On our service this is equal to nine hours per week (six attendants and three nurse's aides). This program is not continuous and covers six week periods.

Because of these classes for all groups of workers we have had no choice but to arrange schedules on a broken time basis. However, we have considered its effectiveness from the standpoints of patient care and nursing energy and have found it more advantageous than the unbroken schedule.

By breaking the time we are able to handle the floor with fewer nurses since we can split the shifts to cover peak loads. However, broken time necessitates frequent reporting to nurses coming on duty. With our present schedule reports are given at the following times: 7 a.m., 9 a.m., 1 p.m., 3:30 p.m., 6 p.m. and 10 p.m.

Reports given properly average fifteen minutes in length. This means, with our present system, at least one and one half hours are spent in giving reports every day, or ten and one half hours a week.

On the unbroken time basis this figure could be cut in half since only three reports are necessary instead of six. However this time is negligible when it is realized that with the unbroken method at least one more nurse per day is necessary to cover peak loads adequately. Many nursing hours are wasted by having a complete staff on the floor during hours when a smaller number would do as well.

Maintaining a satisfied personnel is also a big problem in planning nursing hours. This means meeting requests for special long days, week ends, late hours and holidays.

The problem of evening and night duty is likewise important. The staff nurses at Albany decided on the four week block for night duty and a 5:2 ratio for evening duty. This means five evenings one week and two the next.

The functions of the nursing staff also affect the nursing requirements. For instance, on this division the nurses are responsible for general nursing care, assistance with modern therapies and special treatments and, in addition, they assume many tasks done in other parts of the hospital by subsidiary workers. The nurses are responsible for many housekeeping duties and for the food supply.

Our food trays are not sent from a central station but are set up by the nurses with food sent up from the main kitchen. All breakfasts and many special diets are prepared directly on the floor by the nurses. The nurse is also responsible for making and serving all nourishments to patients. Treatments usually call for "holding of breakfast or dinner." When this is done for 8 or 10 patients the inconvenience and time involved in preparing these meals in the middle of the morning or afternoon is readily seen.

Policies Affect Time Schedule

Certain policies of the institution also influence nursing requirements:

1. No patient is allowed in the bathroom unattended. This rule obtains for toilet, daily tub baths and washing of personal clothing.
2. At least three nurses must be free and stationed on the floor (in solariums) at all times.
3. All patients receiving intravenous or subcutaneous fluids must be attended by a nurse.
4. All patients receiving special treatments must have a nurse for the duration of the treatment and until sufficient time after treatment has elapsed for the patient to have recovered sufficiently not to warrant close observation.

Ordinarily, in determining a nursing service standard, after considering all the factors influencing nursing requirements, the next step would be to make time surveys on routine activities or procedures.

We have found this method unsatisfactory for routine activities. Let us consider, for instance, the time involved in taking temperatures (these are all rectals). Temperatures are taken on the following groups:

1. Newly admitted patients, every four hours for forty-eight hours.
2. Patients with elevated temperatures.
3. Patients receiving treatments.

Thus the number of temperatures is always variable with an average that is difficult to estimate. In addition, it may take thirty minutes to get one patient ready to have her temperature taken and one minute may be sufficient for another patient. The same difficulties are encountered in timing any activity so that it is almost impossible to get a true picture of the average time involved. It would indeed be difficult to staff a unit solely on the basis of these statistics.

Time Studies Guided Program

However, time studies were of value as a guide in planning for special treatments. After a study of four months the following averages were arrived at:

1. Insulin shock therapy ..... 4-5 hours
2. Metrozol convulsive therapy: administration ..... 10-15 min.
   Postconvulsive attendance ..... 5-20 min.
3. Anoxemia (nitrogen inhalation) ..... 15-20 min.
4. X-ray therapy ..... 20-25 min.
5. Electro-convulsive therapy ..... 15-25 min.
6. Intravenous fluids ..... 1½-3 hrs.
7. Lumbar puncture ..... 15-25 min.

Obviously our problem had to be attacked in a different manner. Instead of using time surveys as a basis for our standards it was decided to determine the number of nurses absolutely necessary on the floor hour by hour regardless of census. This was to be the minimum allowance. The head nurse was not included in this minimum.

The following factors had to be considered in determining this standard:

1. Insulin therapy: given daily except on Sunday. This requires one nurse from 7 to 11 a.m. or 12 noon.
2. Metrazol and electro-convulsive therapy: given Monday, Wednesday and Friday.
3. Anoxemia and x-ray therapy: given daily except Sunday.
4. Daily walks: afternoons from 1 to 4 p.m.
5. Daily tub baths: given in the evenings.

The following are the standards arrived at hour by hour for Monday, Wednesday and Friday. (This standard refers only to the female division.)

7— 9 a.m. ... 1 G.S.N.* (insulin)
... 2 G.S.N.'s
... 1 Aide
9—11 a.m. ... 1 G.S.N. (insulin)
... 3 G.S.N.'s
... 1 Aide
11—12 noon ... 1 G.S.N. (insulin)
12— 1 p.m. ... 3 G.S.N.'s
1— 3 p.m. ... 4 G.S.N.'s or
... 3 G.S.N.'s and
... 1 Aide
3— 4 p.m. ... 1 G.S.N.
— ... Same as 1—3
4— 5 p.m. ... Same
5— 6 p.m. ... 3 G.S.N.'s
6— 8 p.m. ... 4 G.S.N.'s or
... 3 G.S.N.'s and
... 1 Aide
8—10 p.m. ... 3 G.S.N.'s
10— 7 a.m. ... 3 G.S.N.'s

Staffing for Tuesday, Thursday and Saturday would be the same as for Monday, Wednesday and Friday except that the extra nurse is not required between 9 and 11 in the morning.

On Sundays the standard would be modified as follows because there are no treatments: (1) eliminate G.S.N. 7 a.m. to 12 noon for insulin therapy; (2) eliminate extra nurse from 9 to 11 a.m.; (3) keep schedule otherwise the same.

*Graduate staff nurse.

Under ordinary circumstances this standard is necessary for a census as low at 10 but, on the other hand, can also care for as high as 15 patients if none of the following circumstances arises which would automatically necessitate extra help even if the census were low:

1. Intravenous or subcutaneous administration of fluid.
2. Continuous tubs.
3. If all insulin patients cannot be placed in one room one nurse is necessary for each extra room used.
4. Extra treatment, such as lumbar puncture and oxygen therapy.
5. Two or more emergency admissions simultaneously.
6. Number of critically ill patients or number of bed patients requiring unlimited bedside care.

From this standard the following figures may be arrived at: average number of patients, 15; head nurse, 1; G.S.N.'s, 8½; aides, 2.

This is equivalent to 5.26 service hours per patient.

From this study it may be concluded that the nursing requirements for this division do not increase proportionately with the census but with the type of patient or the number of modern therapies and special treatments being carried out at the time.

Question of the Month

QUESTION: An attorney who is also a member of the board of trustees of a voluntary hospital performs a considerable amount of legal service for the institution. This service, in addition to advice and consultation, consists of representing the hospital in the surrogate's court in connection with legacies, as well as protecting it in certain litigation. He also represents the hospital in litigation where the hospital is obliged to sue, as well as in the matter of asserting liens that the hospital may possess in connection with services rendered to persons who have been brought to the institution because of accidents on the city highways.

Is it customary for voluntary hospitals to remunerate the counsel for his services or is it expected that he will devote his time without any compensation?—L.O.D.

ANSWER: An attorney serving on the board of a voluntary hospital may well serve that institution in an advisory capacity on various legal problems. The actual performance of such specific duties, however, as representing the hospital in litigation, also in the surrogate's court in connection with legacies should be turned over to some attorney who does not serve the hospital as a trustee but who is retained by it as counsel. Such procedure is generally regarded as fairer to everyone concerned and less likely to cause any embarrassment.

A parallel may be found in the question of architectural services. Any architect serving as trustee of a hospital has much to offer in an advisory capacity but it is better procedure in the event of any major building program to employ the services of outside professional counsel.

Redwoods form the background for the New Trinity Hospital

SISTER M. BERTRAND, C.S.J., R.N.
Trinity Hospital
Arcata, Calif.

THE new Trinity Hospital at Arcata, Calif., of the Sisters of Saint Joseph of Orange, Calif., replaces the old structure which was destroyed by fire in February 1943.

The new building is of modern colonial architecture, erected on an attractive site comprising a square block in a scenic residential section, removed from highway traffic. It has a background of tall old redwoods and thickly wooded hills, for which this section of California is famed. The site was presented to the Sisters by the Arcata chamber of commerce.

The building is of wood construction, with redwood bark insulation throughout, which affords soundproof and fireproof walls. The hospital unit is all located on one floor, with a large and well-planned basement and attic, the latter being easily convertible to additional bed space at a later date.

The entrance to the building is on the west through an inviting lobby finished in the natural color gum wood. The furniture, draperies and accessories are in harmonizing and warm tones of brown, rose and gold.

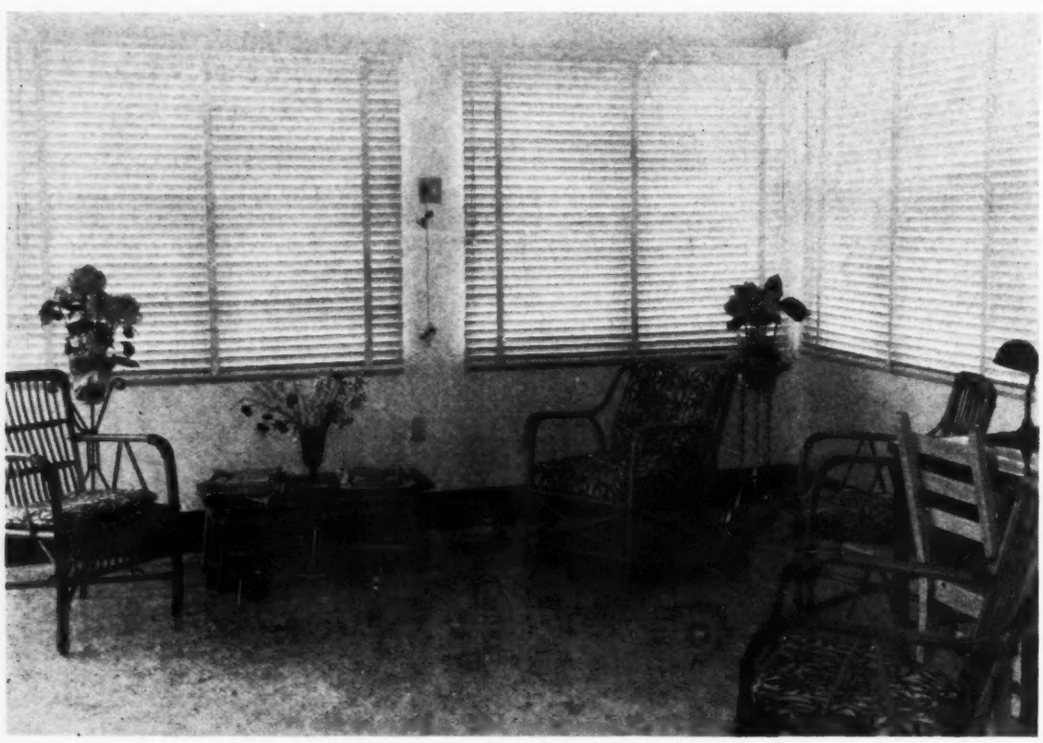
To the right of the lobby are located the administrative offices and a completely equipped pharmacy, while to the left are the laboratory unit and additional waiting room space. The lobby leads onto the main corridor into which open the various departments, private, semiprivate and ward accommodations.

The surgical suite, modern in planning and equipment, and a complete maternity unit front on the west of the building; a most attractive spot is the cheerful nursery with nine tiny bassinets. Both the surgical and obstetrical departments are equipped with ultraviolet germicidal units. Color has been used to advantage here, as throughout the hospital, in wall and floor tiles and in painted surfaces, producing a harmonious and restful effect.

The ambulance and emergency entrance is at the south, and in this area are also located the emergency surgery, x-ray department, pediatric ward and a large and pleasant industrial ward of 12 beds in which complete privacy is afforded for each bed, whenever desired, by curtained cubicles. Adjoining this ward is a cheerfully furnished sun porch for use of ambulatory patients and for visitors.

The dietary unit is in the east section and is planned for central service of all meals and nourishments; trays leave the kitchen in heated food carts. All the modern and time-saving dietary devices have been installed, and the personnel of this unit has as pleasant a place in which to work as can be found in the building.

The present capacity is 33 beds and all department space and facilities

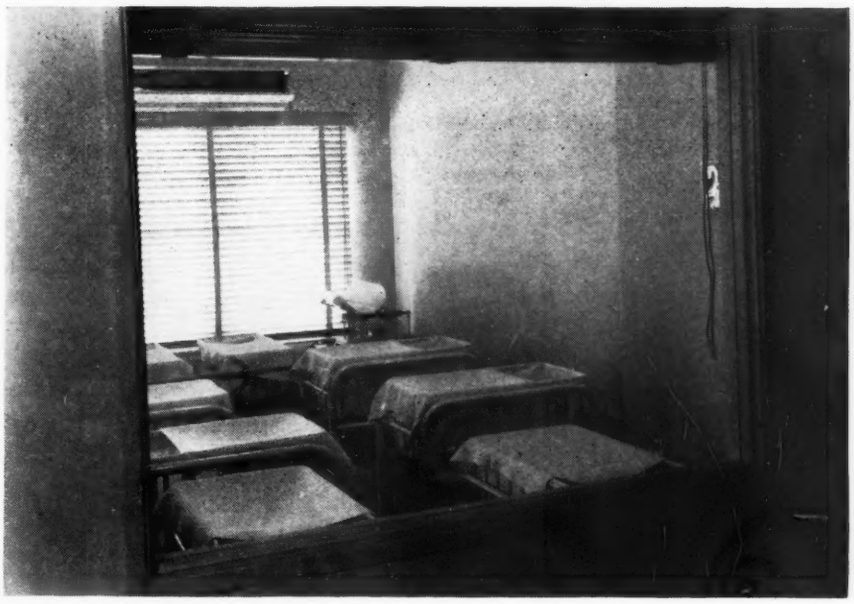


Ambulatory patients, as well as visitors, are welcome to sit in the solarium and obtain the benefit of California sunshine. Plants and cheerful furnishings are used as aids to speed the return to convalescence.

are planned to carry an additional bed capacity. Wood furniture of Swedish and colonial designs has been used in the private rooms, with metal furniture in the semiprivate rooms and the wards.

In arranging the various departments, nursing stations and allied facilities, much thought was given to the minimizing of lost time and energy in traveling between points. The installation of lavatory units both between rooms and between wards permits the nurses to give routine bedside care without going out into the main corridor.

Adjoining the kitchen on the south is a large hallway, which will be converted into a solarium, through which the Sisters can enter their cloister leading to the chapel and home. These two buildings were moved from the former hospital site and were of comparatively recent construction.



A large viewing window enables parents to peer into the nursery which now houses nine bassinets. Ultraviolet germicidal units keep down infections.

The lobby of the hospital is finished in natural colored gum wood. Warm and harmonizing tones of rose, gold and brown were selected for accessories.

Beds in the wards are curtained in order to afford privacy for the patients. Metal furniture was chosen for the wards and wood is used in private rooms.

A concrete runway connects the main building with the laundry. The runway enters the main building in the basement. The basement is large, covering all of the area under the building with the exception of the south wing. This basement space has been well utilized; it contains the walk-in refrigeration units, grocery and supply rooms, a canning room with facilities for the actual canning and storage and additional storeroom space.

The Sisters of Saint Joseph first began their hospital work in Arcata in 1927, when the Trinity Hospital was deeded to them by the city.

Should America Have

Altmeyer Says: YES

ARTHUR J. ALTMEYER

Chairman, Social Security Board
Washington, D. C.

THE medical profession and hospital administrators have a right to be proud of the high standards of medical practice and of hospital care in this country. With few exceptions, our death rate has declined year after year, particularly since the turn of the century. In 1900 there were 17 or 18 deaths per thousand population, as compared with 11 per thousand in 1940. This is indeed notable progress.

Since all this is true, it may be asked "Why is it necessary to embark on a national health program?" And, especially, "Why is it necessary for the government to assume major responsibility?"

The answer is twofold. In the first place, while we have made notable progress in reducing the death rate in this country, we are not the healthiest nation in the world. In the second place, while we have achieved high standards in medical and hospital care, this high quality care is not within the actual reach of large numbers of our people. Putting it bluntly, many Americans this very minute are suffering and dying needlessly for lack of medical care.

But Are We the Healthiest?

The statement has been made many times that we are the healthiest nation on earth, but statistics for the years just preceding the war show conclusively that we are not. Probably the best single measure of our relative health status is the infant mortality rate. In terms of this index, we stood seventh. Moreover, the comparisons in general were increasingly unfavorable to us as we proceeded from the death rates for infants to those of older groups of our population.

We should not draw too much satisfaction from the fact that our death rate has declined markedly since the turn of the century. We should not forget that about 70 per cent of the reduction was made by 1920 and almost all of it by 1930. We must also remember that the major part of the reduction in death rates has been due largely or almost wholly to the reduction in deaths from infectious diseases that are susceptible of mass control. If we are to have anything like a similar improvement in death rates in the future, we must not only expand our efforts in the mass control of infectious diseases but also assure more nearly universal access to individual medical care of noninfectious diseases.

What should concern us more than comparisons with other nations or with former years is the fact that we have given much better health protection in some areas and to some groups than we have in others; we have controlled some types of disease more effectively than we have others. The real measure of our past accomplishments and of our future opportunities is what we can do with our available knowledge. In many parts of the country and among many groups of our people, death rates are far higher than they need be.

For example, many states go through a year without a single reported death from diphtheria or typhoid and paratyphoid fevers, yet other states are reporting three to four deaths from these causes per hundred thousand persons. I cite these diseases not so much because of their present importance as causes of death but because they are diseases that can be prevented nearly 100 per cent with proper public health and medical measures, and yet they continue to snuff out many lives annually.

Infant mortality illustrates similar wide differences among the states. In 1943, the state with the lowest infant mortality reported 29 deaths per thousand live births; the state with the highest mortality had more than 3 times that rate. In some half dozen states with the highest infant death rates, at least half the babies who died could have been saved had they been fortunate enough to have been born in areas where conditions were more favorable for their survival.

Medical Care Makes a Difference

In this connection, the relationship between infant mortality and medical attendance at birth deserves mention. In the 10 states with the lowest infant mortality in 1942, 88 per cent of the births in that year took place in hospitals and less than 1 per cent of the births lacked medical attendance. In contrast, in the 10 states with the highest infant mortality, only 47 per cent of the births were in hospitals and 12 per cent had no medical attendance.

The availability or absence of medical care is not the only reason for these and other differences in the security of life in the United States. Differences in economic circum-

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Compulsory Health Insurance?

Mannix Says: NO

JOHN R. MANNIX

Director, Plan for Hospital Care
Chicago

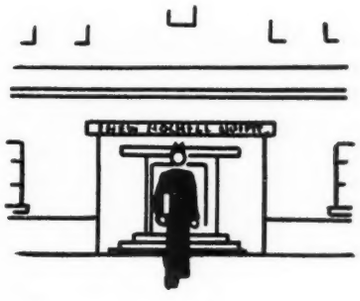
MR. ALTMEYER presents the over-all case for compulsory governmental health insurance so plausibly and so sincerely that it almost seems poor taste to take exception. Yet the plain fact is that he jousts with windmills. His program will not and cannot work the way he says it will. His reasoning is shaky, his facts and figures are wide open to challenge and he exhibits an appalling faith that everything will work out beautifully if we close our eyes and wish hard enough.

Furthermore, Mr. Altmeyer treats his entire subject as though there were no alternative solution to the problem he outlines. On the ground that they have not yet reached their ultimate goal, he dismisses as unworthy of detailed consideration the remarkable progress and immense promise of voluntary methods toward meeting the same problems.

Record Cannot Be Ignored

Leaders of the voluntary movement have a record of practical accomplishment that cannot be overlooked in any examination of the facts. This record is secure despite the fact that they have acted under a continuous barrage of criticism and attempts to minimize from the spokesmen for compulsion. They have built a framework within which the dream of better health for all Americans can quickly become a reality and they have planned in considerable detail the exact methods to be used in realizing this dream.

There is no need here to itemize the unprecedented present rate of



growth of Blue Cross and nonprofit medical service plans. The 21,000,000 persons enrolled in Blue Cross today are scarcely more than a substantial fraction of the number who will be enrolled for improved and broader protection tomorrow. The point is that all this is brushed aside as meaningless merely because the job is not yet complete.

In challenging Mr. Altmeyer's statements, then, I think it essential to begin with his premise. This premise is that only government can assure adequate health service for all the people.

It is strange indeed that this fallacy is accepted today in so many quarters and in so many different connotations. Clearly, it rests almost entirely upon the argument that only government can exercise compulsion and that compulsion is necessary.

I do not believe that Mr. Altmeyer is serious when he asserts that the compulsion would be applied only to the public in the collection of health insurance taxes. The mere paying of taxes does nothing but assure the accumulation of funds which can be used to pay for health services. It does nothing whatsoever to assure the delivery of the health services.

Mr. Altmeyer's whole argument is predicated on the assurance that the services would in fact be delivered and that these services would meet high standards. It is idle to assert that compulsion on hospitals, doctors and the other professions would not be involved. The compulsion would be economic. It would be backed by the weight of billions of dollars. Like any monopoly, it would be virtually irresistible.

At the very outset the American people should ask: Who is going to determine the purposes to be served by that compulsion? The quality and nature of hospital and medical care today are determined directly by public demand. Will the new governmental system conduct public opinion polls to discover what kind of service the people want and where they want it, or will some governmental board arbitrarily strike a compromise between what it considers to be the public desire and what it deems to be good for the people? The morass of difficulty which engulfed the O.P.A., even under the extreme exigencies of war, should be sufficient warning in regard to this situation.

Compulsion Is Opposed

The mere idea of compulsion, moreover, is antagonistic to the principles of American democracy, and there are sound reasons why this is so. Our democracy was founded on the conviction that the majority of the people are sufficiently resourceful, intelligent and sensible to govern themselves and to direct their own individual destinies. Obviously, there are always those persons whom society must support and protect.

To insist that *all* the people must be compelled to do that which is good for them, however, is a radical break from the democratic concept. There is no stopping point once this philosophy is accepted as a rule of

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stances, and consequently in housing and living conditions, no doubt contribute to the differences in death rates. No economic factors, however, are as significant as is the availability of public and individual provision of health and medical services.

It is still commonly said that the poor and the rich get the best care. This oft-repeated generalization has caused much confusion. The fact is that poor people have more illnesses and have higher death rates than the well-to-do, but they receive far less medical care per family and per case of sickness. Poverty, illness and inadequate medical care go together.

The Poor Are More Often Ill

The national health survey, conducted by the U. S. Public Health Service in the winter of 1935-36, showed that there were 2½ times as many days of disability among persons on relief as among those having a family income of $3000 a year or more. The number of days lost by persons not on relief but with a family income of less than $1000 was twice that experienced by those with a family income of $3000 or more.

This survey also showed that while there was much more serious disability among those with the least income, a substantially larger proportion among them than among those in the higher-income brackets failed to receive any medical attention whatsoever. The survey also showed that disabled persons in the low-income brackets who did receive medical assistance had had fewer visits from physicians than had disabled persons in the higher-income brackets.

Summing up the results of various surveys, it appears that the amount of medical care received by persons in the low-income brackets has been about one third as adequate in amount as the care received by those in the upper-income brackets. The reason for this difference should be obvious. Medical care costs money and the poor have less money to pay for it. Various public opinion polls show that from 30 to more than 40 per cent of the American people have put off going to a doctor because of the cost. Individual doctors are not to be blamed for this. Financial barriers, not doctors, are the cause of the inadequate medical care which our poor people receive.

If we agree that nobody should suffer or die for lack of access to medical care, do we not have an obligation to break down the financial barrier between sick people and their doctors and hospitals? Is a democratic government meeting its full responsibility if the primary essential of human existence, the health of the people, is not safeguarded and improved to the utmost extent that medical science and our resources make possible?

That this is an accepted responsibility of government is recognized by the fact that our government has already gone a considerable distance in protecting and promoting the health of the people. In addition to public sanitation and public health services, we have provided public medical service for the indigent, though with widely varying degrees of adequacy in different localities.

Nor has governmental assistance for medical care been limited to indigents. In 1944, 85 per cent of all the beds in tuberculosis hospitals were in government-operated institutions. Hospitalization for persons afflicted with nervous and mental disease has become almost exclusively a government function, and this hospitalization has by no means been limited to the indigent.

Rôle of Government Increases

Even in the field of general hospitalization care the rôle of government has become increasingly important. In addition to the hospitals for veterans and other wards of the federal government, about 28 per cent of all the beds in general and special hospitals are in government-owned institutions. Through workmen's compensation laws, the state and federal governments have assured medical services for work-connected accidents and diseases.

The federal government has always been responsible for the medical services of the armed forces. In addition, it has provided hospital and medical care for merchant seamen for a century and a half. For more than a quarter of a century special provision has been made to assure hospital and medical care for veterans. This activity is destined to grow by leaps and bounds. Thus, it is estimated that in the next 30 or 40 years the government will be providing hospital and medical care for 15,000,000 or 20,000,000 veterans.

Under the Social Security Act, the federal government has made grants-in-aid to states for maternal and child health services, services to crippled children and state and local public health services. It also has been providing funds for the control of venereal diseases. Since 1942, the federal government has been paying for the maternity and infant care of the wives and infants of servicemen. During the last fiscal year the expenditures under this program alone amounted to $45,000,000. Last year the new Public Health Service Act became law, increasing the financial support for public health and for research and authorizing a new, large-scale attack on tuberculosis.

Spent Nearly One Billion

All in all, in 1944 governmental expenditures, federal, state and local, for public health and medical services, exclusive of medical care for the armed forces, totaled nearly a billion dollars, or one fifth of all the expenditures for health and medical care in the United States.

Thus, it is apparent that the question before us is not whether the government should assume responsibility for protecting and promoting the health of the people but, rather, how much farther the government should go in meeting that responsibility.

The President of the United States placed his views before the Congress in his message of November 19, in which he outlined a national health program. The President's program consists of five proposals: (1) federal grants-in-aid for hospitals and other health facilities throughout the nation; (2) federal grants-in-aid to expand public health services and maternal and child health services; (3) federal grants for medical education and medical research; (4) a nationwide system of health insurance, and (5) compensation for wage loss resulting from nonindustrial disability.

The proposal for a nationwide system of health insurance is the most controversial and is probably of the greatest concern to physicians and hospital administrators.

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practice rather than exception. If need—the good of the people—is to be accepted as its justification, government could do more for our national welfare and our national health by closing all night clubs, standardizing the American diet, prohibiting the sale or use of tobacco, as well as liquor, and insisting that every person get at least nine hours of sleep every night.

Social Security Cited

It is the practice of proponents of compulsory governmental health insurance to cite the present social security system in arguing that the principle of compulsion is not antagonistic to American democracy. Mr. Altmeyer utilizes the same expedient in evident oblivion to the irony of the comparison. Our present social security system still does nothing for the indigent, the self-employed, the farming population or even the government's own employes. In these classifications are to be found most of the people whose health conditions have motivated the present great hue and cry.

In the larger sense, however, the problem is not that of some compulsion or no compulsion. The mere fact of government implies compulsion within government's proper sphere. Our most important domestic controversies of today have to do with this question of the proper sphere of government. It will never be finally answered because conditions perpetually change.

Nevertheless, it is fairly easy to settle this problem in regard to any specific issue by making necessity the criterion. If there are important public needs that are not being met and cannot be met by voluntary activity, then it is incumbent on government to take action. Some such situation resulted in our present social security system, but no such situation prevails in relation to health care. I have mentioned voluntary activity in the health care field. The importance of this voluntary program cannot be overemphasized.

Mr. Altmeyer does more to weaken than to strengthen his case by outlining the extent to which government already has assumed responsibility for health care. He is quite right in saying that government must have certain health responsibilities. The way in which government has met some of those responsibilities, however, constitutes anything but an inducement for us to delegate practically all health responsibilities to the government.

What the common man must fear everywhere is concentration of responsibility and its concomitant concentration of authority and power. Governmental monopoly is as fatal as private monopoly, but governmental monopoly is exactly what is proffered in connection with health care.

All Mr. Altmeyer's promises of free choice of hospitals and doctors, free choice of methods of remuneration, noninterference with professional relationships and cooperation with voluntary organizations are beautiful day dreams. I believe that those promises are offered in all sincerity but they represent little more than wishful thinking. It is hard to see how anyone who has had experience with the arbitrary nature of government's directives, regulations and restrictions in other fields should expect the millennium under governmental health insurance. It just isn't possible.

The over-all argument of proponents of governmental health care invariably contains one additional point, and Mr. Altmeyer makes use of this indirectly. It is the point which insists that government alone is capable of developing the master plan by which all health services will be integrated and coordinated.

There is, of course, nothing to prevent government from developing such a plan or from conducting a program to encourage cooperation of voluntary agencies in it. Actually, government has not developed such a plan and has not even made any well-organized effort to ascertain the exact nature and extent of the weaknesses in our present health system. Without knowing the true needs of the nation, without having any conception of the costs of meeting those needs, it is proceeding toward compulsory health insurance almost wholly on the basis of enthusiastic guesswork.

In every respect, examination of Mr. Altmeyer's premises demonstrates them to be wholly untenable. It will be observed that proponents of compulsory governmental health

insurance have carefully avoided debate on these premises. They consistently advance their arguments by asserting that each successive new proposal eliminates objections raised in regard to the details of previous proposals. This is tantamount to arguing in advance of trial whether the accused is to be hanged or shot. The basic issue is completely ignored.

It is my conviction that spokesmen for voluntary methods must not permit themselves to be diverted from the basic issues in the heat of argument over details. However, the evaluation of details can serve a good purpose if presented in proper perspective.

Mr. Altmeyer's dramatization of the health weaknesses of our nation provides a case in point. It creates a wonderful diversion. It induces any conscientious but inadequately informed citizen to cry out that "something must be done." The fact is that a great deal is being done, and being done rapidly. And it is a further significant fact that the status of the nation's health can be argued indefinitely without reaching a conclusion.

No True Basis for Comparison

Let us examine this case, however. Mr. Altmeyer states that "the United States is not the healthiest country in the world." He quotes infant mortality rates to support his assertion. But he does not tell us which nations are healthier. Actually, not one of those nations with lower infant mortality rates is sufficiently similar to the United States to afford a true basis of comparison.

Even so, Mr. Altmeyer can be challenged on his original assertion. For all its great diversity of population, of economic circumstances and of educational levels, the United States has achieved a health record that is by no means discouraging when aligned with that of any other nation.

Mr. Altmeyer compares infant mortality rates, as previously cited.

(*Concluded on Page* 72)

ALTMEYER

Why cannot normally self-supporting families be expected to pay for their own medical care either directly or through voluntary insurance plans of one kind or another?

We can all agree that building hospitals and other health facilities is not enough unless provision is made so that sick people can avail themselves of these facilities. Unfortunately, in the very nature of the unpredictable incidence of sickness, it is impossible to draw a line between those who will and those who will not be able to pay for the health services they need.

Medically Indigent Defined

"Medically indigent" is a statistical term to describe classes of persons rather than individuals. Whether a given individual falls within the classification of medically indigent depends not only on his income but also on the amount of sickness that he happens to have. Dr. R. G. Leland, director of the bureau of medical economics of the American Medical Association, presented data in 1939 in which he showed that people with an income of less than $3000 a year may be medically indigent under certain circumstances, depending on the type of illness they suffer.

In 1935-36, more than 92 per cent of the people in this country were in families that had an income of less than $3000. Even with the increase in per capita income since that time, the majority of people in this country still have an income of less than that amount which, of course, purchases far less today than it did ten years ago. Therefore, the fact remains that only a fraction of our people can pay for all needed medical services for serious illnesses.

The only way most of the American people can meet this problem is by spreading the cost of medical care over sufficiently long periods of time and among large enough groups of persons so that the cost will not be unbearable in the individual case. If this were done, and the average amount were adjusted according to income, the cost of adequate care would not be unbearable even for persons with relatively small incomes.

Some people have suggested that it should be sufficient to spread only the cost of so-called catastrophic illnesses, that is, illnesses costing more than a certain amount. However, one disadvantage of that approach is that people of low or medium incomes would still have to bear a considerable cost. Another disadvantage is that if they had to pay, for example, the first $50 of the cost, they would still be deterred from consulting their physicians early in the course of a disease or for an apparently minor illness which later proved to be serious. Thus, the great advantage of early diagnosis and early treatment would be lost.

If the problem is to spread the cost of medical care, why can't we rely on the individual to obtain his own insurance? Hard facts spell the answer. The poor cannot afford to pay the full insurance premium. Most of those who are normally self-supporting have immediate wants which press on them to the exclusion of protection against future possible costs that may not actually occur. In other words, our day-to-day wants and necessities induce us to take a chance.

It is true that many people have insurance against the cost of hospital or medical care. The Blue Cross movement, in particular, has shown remarkable progress in the last ten years. However, the present membership covers less than 13 per cent of our entire population and is made up chiefly of people in the middle-income brackets, who live in or adjacent to the larger cities.

Prepayment plans for medical care came before the Blue Cross hospital plans, but they have not shown such rapid or extensive growth. Some medical society plans that started out to provide comprehensive services have found their growth discouragingly slow and have restricted their main coverage to surgical expenses in hospitalized cases only. At present, membership in voluntary medical prepayment plans—which seldom provide complete or comprehensive medical services—includes about 5,000,000 to 6,000,000 persons.

Commercial group insurance covers 8,000,000 persons for hospital and surgical indemnity insurance, of whom about 6,000,000 are covered for surgical indemnity. The number of individual insurance contracts for indemnity of hospitalization and other medical care costs is not known. While it may be large, the scope of the protection is usually narrow, since many of these policies cover only costs incurred for particular types of accidental injuries rather than sickness costs of all kinds, and many have other important limitations.

It is possible that, altogether, about 40,000,000 persons have *some* voluntary protection against the costs of hospitalization or medical services. While this protection is significant, the available figures indicate that voluntary insurance alone does not assure adequate protection for most Americans against the cost of medical care. Moreover, when we consider the economic status of those who now have such protection and of those who do not have it but do experience more frequent and serious illnesses, it becomes all the more evident that voluntary insurance is not a complete or adequate answer to this national problem of spreading the costs of medical care.

Two Ways to Spread Cost

There are two possible ways in which the government can undertake to spread the costs of medical care. One is to provide medical care free of charge to the recipient, financing it through general taxation. The other way is through a system of health insurance, financed largely through contributions by potential beneficiaries and their employers.

Under the first approach, medical care would be provided just as education is now provided. The practitioners would probably be for the most part salaried officials employed by the agency of government that provides the medical services. Such a system is usually termed "state medicine" and sometimes "socialized medicine." However, these terms are so indefinite and confused that they are sometimes used to cover not only public sanitation, public health services and medical services provided by government for specific groups in the population but also health insurance.

It is essential for clear thinking that the distinction between state medicine and health insurance be kept in mind. State medicine implies medical services provided by physicians employed by the government; health insurance, on the other hand, implies a system whereby medical service is provided by private competitive practitioners who are reim-

bursed from a special insurance fund for the services they render.

In other words, state medicine is not only a system for spreading the cost of medical care but also a system of medical practice; in contrast, health insurance is a system for spreading the cost of medical care and does not replace the competitive private practice of medicine. Only the Union of Soviet Socialist Republics has a national system of state medicine; more than 30 countries have national systems of compulsory health insurance.

Every state but one already is operating a system of compulsory health insurance applicable to accidents and diseases arising out of occupation, that is, workmen's compensation. I am sure that no one would think of abandoning workmen's compensation insurance. In the broader sense, health insurance is merely more inclusive than workmen's compensation; it covers *nonoccupational* accidents and diseases.

It would be possible to have a system of health insurance on a strictly state-by-state basis, like workmen's compensation, without any assistance from the federal government. Or it would be possible for Congress to enact legislation which would create a strong inducement for the states to enact such laws, as was done in the case of unemployment compensation. Or it would be possible for Congress to enact a wholly federal health insurance law.

Should Decide on Remuneration

The administration of the benefits should be decentralized so that all necessary arrangements with doctors and hospitals and public health authorities could be subject to adjustment on a local basis. The local hospitals and doctors should be permitted to choose their method of remuneration.

The method of remunerating hospitals could be on a fixed per diem basis regardless of the cost of the service to the hospital or the patient, or it could be on the basis of the actual cost of the service to the hospital—within fixed minimum and maximum limits, or it could be a combination of the two methods. The payment of doctors could be on the basis of fee for services rendered or a per capita fee per annum, or straight salary—part-time or full-time —or some combination of these.

Besides free choice of method of remuneration, the system should provide, of course, free choice of physicians and free choice of patients. The professional organizations themselves should be relied upon to assist in the maintenance and promotion of desirable professional standards. Voluntary organizations that provide health services would have an important rôle under a system of health insurance. Voluntary cooperative organizations that are concerned with paying doctors, hospitals or others for health services but that do not provide services directly or pay for services rendered could also play an important part in simplifying administration, promoting desirable professional relations and furnishing, or arranging to furnish, adequate medical care promptly and efficiently.

President Truman in his health message specifically stated that such voluntary plans should be preserved, used and encouraged. Last year, a group of 29 leading authorities, including 13 physicians, made a careful study of principles and policies for a national health program and concluded that it was desirable and practicable to utilize voluntary agencies in the administration of such a program.

Many state medical societies have worked hard to set up systems of prepayment of medical care. Several of these plans have met with considerable success. Whether or not they have met with success, these plans represent an earnest attempt on the part of organized medical groups to spread the cost of medical care while maintaining the professional relations desired by those groups.

However, they have all experienced one great difficulty that a general system of social insurance would overcome, the hazard of adverse selection. Any prepayment plan covering persons who can enter it and leave it at will is subject to this handicap. Under a general social insurance system, however, the problem of adverse selection is solved automatically, since the good risks, as well as the bad, are included.

Under a system of health insurance, the government could make arrangements to deal with the voluntary groups that furnish health services directly or pay for services rendered. The simplest arrangement would be for the government to reimburse the organization either on an individual patient or service basis, or on an estimated total cost basis.

Such arrangements not only would provide for utilizing existing service organizations but would encourage the creation of new ones. Such voluntary plans could be administered by groups of doctors, individual doctors or many other kinds of individual or group sponsors. Any such plans would be as free as they are today to select their own staffs and their own method of paying doctors and others on their staffs.

Moreover, the method of paying a group for services rendered by its physician members can be readily adapted to avoid adverse selection. For example, if the group is large and undertakes to serve a whole area or population group, it could receive a pooled payment from the insurance fund for all insured persons in the area or population group. This is payment according to number of persons and is generally known as capitation; the payment covers the well and the sick. Or, if the group prefers, it could be paid for the sick only, on a fee-for-service basis—so much for this service and so much for that. In either case, the group is protected against adverse selection.

Payment Must Be Adequate

Under *any* method of payment, the rate and amount of payment to doctors should be adequate. This means adequate payments for general practitioner services and adequate payments for specialist services. The medical profession has a right to insist that the financial resources of a health insurance system shall be sufficient to pay adequately for high-grade services. Since the public would receive a larger amount of service with health insurance than without it, physicians as a whole would have a right to expect higher average incomes than they ordinarily receive.

Even ready access of the public to needed care and adequate payments to those who furnish care are not enough. There are fundamental questions with regard to safeguarding the quality of care and continuing professional progress. By and large, it seems to me that quality of care should improve rather than de-

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cline if payment for service is guaranteed. It is alleged, however, that other characteristics of an insurance system will dominate the picture. One hears about "regimentation" of doctors, "assignment of patients," "political control." If the fee no longer stands between patient and doctor, the competitive relation between doctors will still remain, but it will rest on quality and adequacy of care. These are essentials for continuing good care. Where then are the issues?

One question concerns control over the professional aspects of medical practice. The guidance, the direction, the supervision, the discipline of doctors are primarily matters for doctors to handle. Subject to government regulation through licensure, the responsibility has always been the profession's. No government officer in his senses would take any other position. Just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation and establishment of voluntary insurance plans—to mention only a few—gave new opportunities to exercise professional controls, so inauguration of health insurance gives still another in the long evolutionary movement for high ethical and qualitative standards. On this broad question, health insurance presents not a major threat but a new, great opportunity.

Another question is summarized in the phrases about "regimentation" and "a czar over medicine." There is one sure way for the medical profession to see that what it doesn't want doesn't happen, even by inadvertence, and that is to participate in planning the program. There is no problem here that can't be solved by men of good will.

From a talk at the annual Conference of Presidents and Other Officers of State Medical Societies, December 1945.

MANNIX

One of the best indices of national health is the average life expectancy at birth. Analysis of the life expectancy figures for three nations—the United States, Sweden and New Zealand—demonstrates admirably the ease with which figures can mislead.

At first glance these figures seem also to indicate that the United States suffers in comparison. In 1942 the life expectancy of the average American male at birth was 63.65 years, whereas the life expectancy in Sweden for the period of 1931-35 was 63.22 years and that in New Zealand for the period of 1934-38 was 65.46 years.

However, when the comparison encompasses the relative progress of the three nations during recent decades, our country moves clearly out in front. In approximately four decades the average life expectancy in New Zealand lengthened by about ten years, in Sweden, by about twelve years and in the United States, by about fifteen years. Here is evidence that the United States is progressing more rapidly. Can it be seriously argued that we should abandon the system which is resulting in the greatest progress?

Mr. Altmeyer is on much firmer ground when he points out the inequities existing between levels of health in various sections of our country and in various economic brackets. Certainly these inequities exist. Certainly they must be corrected. But if it is the government's contention that health insurance of itself will correct these inequities or is even the direct line of approach toward correcting them, then I think that we can place little faith in the ability of the government to help this situation at all.

Obviously, health insurance reaches only the self-supporting above some indeterminate income level. The insurance principle encompasses the pooling of funds to equalize risk; it does not apply to those persons who have no funds to contribute. If the latter unfortunates are to be subsidized—as indeed they must be—it insults common sense to suggest that all the self-supporting must be forced into an insurance system for this sole purpose.

A careful definition is made in Mr. Altmeyer's paper of the distinction between "state medicine" and health insurance. This is equivalent to insisting that there is no relationship between cause and effect. Compulsory health insurance is not state medicine; it is state insurance. Automatically, however, it will result in state medicine.

Government Would Dictate

It makes little difference whether the government employs doctors on a salary basis or sets fees and decides how many patients the doctor may have. Both the medical profession and the hospitals would be dependent upon the government for their incomes and for the decisions as to what kind of services they could render and to whom they could render those services. It might also be asked how government expects to improve the situation in our low health areas without some even more direct form of state medicine than this.

The nation is on the verge of committing itself permanently to a dangerous and unsound system of health care. The advocates of compulsion have painted a picture that seems to have hypnotized the public. Advocates of voluntary methods must paint an even better picture. It must be a complete picture and it must be brought into the light where the people can see it. Unfortunately, the American people, including many who are relatively well-informed, have little understanding of the nature, purpose and promise of our voluntary plans.

Our hospitals, our doctors and our other "purveyors of health" cannot move too fast to avert a national tragedy. They must say emphatically that voluntary methods are the best assurance of that better health care which we all seek; they must tell how and why, and they must prove their case rapidly with constructive deeds.

Quiet Please

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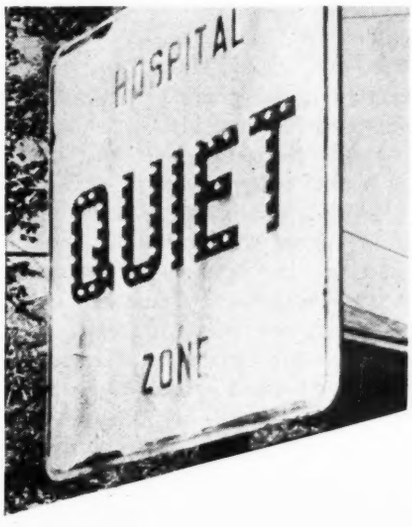
IN EVERY Pullman car, as soon as the berths are made up, a sign appears which says "Quiet is requested for the benefit of those who have retired." As a general rule this sign is respected. Seldom are Pullman cars disturbed by noise other than the necessary noise of railroad operation. In hospitals, on the other hand, quiet is among the rarest of blessings for the patient who so badly needs rest.

The routine of hospital care is generally considered to require an early start in the morning so that all the necessary face washings and other care can be given, breakfast served and the routine services rendered the patients in time for the morning rounds by the doctors and interns. This is probably correct, at least when staffs are limited.

There has, however, crept up in the minds of many observers, particularly doctors who go into hospitals as patients, that some of the hospital routine is more ritual than necessity. Unless there is special need for it, the daily bed bath is a time-consuming procedure which might be omitted with profit under some circumstances, allowing the patient more time for rest.

There are patients who like back rubs, and those who do not; the latter get them nevertheless, even when the patient is in the hospital only for observation and is up and around whenever he pleases. Many a patient has gone home from the hospital with a heartfelt sigh of relief at the chance to get a rest from the hospital routine, all of which is intended for his benefit but much of which succeeds simply in tiring him out.

A doctor who goes into the hospital not as a staff or attending physician but as a patient or the relative of a patient gets an extremely useful slant on hospital policies. Take, for example, the matter of radios. It has become customary for radios to be permitted in hospitals, at least in private and semiprivate rooms, and not infrequently in wards. The patient who is weathering the postoperative storm is in no mood for boogie woogie or soap operas and yet, if the patient in the next bed or the next room, or sometimes even far down the hall, is inconsiderate and is equipped with a loud radio, no one within ear-shot has any defense.



Sick patients or their relatives may request the floor nurse or even the supervisor to quiet the loud radio. The usual result is from thirty minutes to forty-five minutes of comparative quiet after which the noise starts up again. Sometimes it is even louder than it was in the beginning as if a gesture of defiance were being made.

Physicians universally recognize rest as the most important essential of medical care, yet staff and attending physicians are powerless to prevent the operation of loud radios by inconsiderate convalescent patients, observation patients or obstetrical patients waiting for something to happen, because the hospital management is timid about giving offense.

The whole matter could be solved by prohibiting radios except those equipped with ear phones or by providing such radios on a rental basis and prohibiting the bringing in of privately owned radio speaker receiving sets. Fear of offending the inconsiderate puts the sick patient at

an unnecessary and inexcusable disadvantage.

Another matter on which it is time hospital managements took a stand is that of smoking. Thirty years ago no one would have thought of smoking in a hospital, except in the doctors' lounging rooms. Today few hospital corridors are without their trail of cigaret smoke, most of it regrettably issuing from feminine lips. Most of the doctors still leave their cigars, cigarets or pipes in the lounge provided for that purpose.

Smoking on duty by hospital personnel is, of course, not tolerated. The patients and their visitors have no restrictions placed upon them. Men visitors still retain some sense of the fitness of things and customarily refrain from smoking in hospitals. But not women.

Women who smoke seldom have any regard for the annoyance which they may cause to nonsmokers, and their conduct in hospitals is no exception. Add to this the fact that few feminine smokers know how to smoke but for the most part simply permit their cigarets to burn and smell, and the situation becomes almost intolerable for patients whose illness makes cigaret smoke difficult to bear.

If such patients have private rooms, they have some control over exposure to smoke, but if they are compelled to go into wards or semiprivate accommodations, they are at the mercy of the first inconsiderate convalescing or observation patient or other not-very-sick individual who may choose to exercise the opportunity—if not the right—to be a nuisance.

Rules Present a Paradox

From the standpoint of the patient or the relatives of the patient, hospitals present a strange paradox. They have sufficiently rigid rules governing visiting hours and excluding visitors from the operating and maternity pavilions and from the nursery. They enforce these rules without fear and sometimes without the good judgment which would make exceptions under suitable circumstances. But when it comes to the loud radio or the human smokestack, they cringe for fear that something will go wrong with their public relations if they dare to speak up and enforce "no smoking" signs and put a ceiling on radio decibels.

These suggestions are not intended as "gripes." I have had experience with the management of two communicable disease hospitals and an Army hospital and recognize the difficulties involved. It does seem, however, that there is a confusion of values when the visitor, the convalescent or the otherwise not very ill patient is permitted to do things in the hospital which react against the comfort and well-being of sicker patients, and which may be a factor in the recovery of such patients and, occasionally, though perhaps not commonly, influence their chances of survival.

Inspections Are Worth the Effort

JOHN F. CRANE
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I HAVE repeatedly observed on transatlantic crossings that promptly at 11 each morning the chief officer, the doctor, the chief engineer and the purser jointly inspect the various departments of the ship. A valuable lesson might be learned in our hospitals from this shipboard procedure now that the war is over and we are approaching a full employment level.

During the war years most of us made rounds mostly out of habit and also because we were expected to be seen in various locations of the hospital at unexpected times. During the critical period from which we are now emerging we often noticed inefficiency that would not have been tolerated in normal times. Rules and regulations were often set aside arbitrarily by workers. Unless patients and loyal workers were placed in jeopardy, we did not or could not remedy these situations.

Visited All Parts of Building

In prewar days it was an accepted procedure for the executive to make rounds whenever it was convenient for him to do so, provided, of course, that all parts of his hospital were visited frequently. Armed with a scratch pad and pencil he would make notes and on returning to his office would instruct department heads accordingly. Occasionally, if the condition warranted it, the executive would telephone the department head and wait at the scene until he arrived and then ask for explanations.

These trips of inspection through the hospital buildings served two necessary purposes: (a) they helped to round out the picture for the executive and kept him up to the minute on the physical aspects of the plant and buildings and (b) they helped to keep employes on their toes, especially so when night rounds were made.

However, we should go a step farther and make what might be termed administrative grand rounds from time to time. For this purpose the executive should be accompanied by the superintendent of nurses, the chief engineer, the housekeeper and, in a hospital that has a number of pantries scattered throughout the buildings, the dietitian.

The Time Is Not Wasted

At first glance this might seem like a time-wasting affair (one hour of inspection would thus equal five hours of administrative time). However, it often proves both a money and time saver. In making such combined rounds we frequently find expensive items, such as adhesive tape and gauze, being used for illegitimate purposes. For instance, some people prefer to use adhesive instead of thumb tacks and gauze instead of rubber door silencers.

The old story of unnecessary lights burning; water faucets, both hot and cold, leaking, and radiators turned on in unoccupied rooms is known too well to be repeated here. If, however, the department head concerned is a party to the discovery of such waste the chances of putting a stop to it are much better than by the use of the telephone or memorandum method.

The Doors to Administration are all too narrow

JOHN W. RANKIN
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Sumter, S. C.

THE many administrative problems of medical care in rural areas revealed by war-time conditions have left impressions on both the public and hospital trustees that will stimulate, or retard, progress in hospitals serving rural areas.

The vital concern to the trustees of these rural institutions is: where are the trained hospital administrators coming from? Boards of trustees are no longer willing to turn over the administration of a complicated business, worth from half a million to two million dollars, to an inexperienced person. The days of training by trial and error have proved to be too expensive both in dollars wasted and in standards of hospital care produced, one being no more important than the other.

The institution I have in mind is the community hospital, city, county or nonprofit association, serving a population of from 20,000 to 100,000 with from 50 to 200 beds, usually located in an urban center but also serving a large rural population within a 20 to 40 mile radius.

Fifty Year Lag in Education

There are now three doors leading to the position of administrator of this type of institution. It is the thesis of this paper to demonstrate that these three doors are not large enough to turn out the necessary number of administrators, nor is the program for training coordinated. In reality, the education of hospital administrators is 50 years behind the education of doctors, lawyers, business executives and other trades and professions on a comparable salary level.

First, let us consider the front door. This is the door of formal education as exemplified by the person finishing a course in hospital administration at Duke Hospital, the University of Chicago, Northwestern University, Columbia University and other institutions that have an organized plan of teaching hospital administration by both the lecture and apprentice method. In a group of 145 hospitals selected at random in the seven southeastern states (from 50 to 200 beds serving rural areas up to 100,000 population), only five hospital administrators came in the front door.

This 3 per cent is proof enough that the front door to hospital administration is not large enough. It also leaves the implication that those who enter by it do not choose to work in rural hospitals. These men may be motivated by the same influences that move the young medical graduate to want to locate in a large urban hospital center.

At this point we must evaluate the relative importance in the field of medical care of the type of institution under consideration. Since in the seven southeastern states under discussion this type of institution serves 75 per cent of the general hospital patients, it can only be assumed that it is nothing less than the backbone of medical care for the large majority of people in this area.

The side door to administration of the small rural hospital is the apprentice method. There is no question as to the quality of the product from this process of education for hospital administration. The chief difficulty is that too few are trained as hospital administrators in this type of institution. Those who are receive their training by accident rather than by design. For example, a bookkeeper in a 200 bed hospital gets the job as administrator of a 50 or 75 bed hospital; a graduate nurse drifts into the field through a supervisor's job. This process does produce good hospital administrators but it does not produce them in the quantity needed or on a planned basis.

The back door is the one that is used too often with results that are a burden to the institution and to those who support it. I am speaking of the too many people who come into the position of hospital administrator without ever having worked in a hospital. This back door exists for two reasons, both of which can be traced to a fundamental lack of education on the part of the trustees. One is politics; the other is a result of the law of supply and demand. There is no trained person available so an untrained person is selected.

Those who come through the political back door seldom make a success because they have no reason or incentive to learn the profession; they feel secure because they know they can keep their jobs through the same means, politics. Those who enter through the back door from successful and responsible positions in other fields often prove successful but only after a long period of learning by trial and error.

There Are Incentives

Therefore, there is no question that the demand for trained hospital administrators is greater than the supply in hospitals of rural areas of the South. What then is the incentive for one to aspire to such a position? Relatively, I would say that it is quite good. The average salary of the hospital administrator in an institution up to 50 beds is $2500 per year; from 50 to 100 beds a salary from $3600 to $4200 is not unusual, and from 100 to 200 beds a salary from $4800 to $6000 is to be expected.

In general, in urban areas with one or two nonprofit institutions, the salary of the hospital administrator is usually comparable to that of the superintendent of schools, of ministers of the larger churches and of those in high public administration or local government positions.

The quality of the administrator who enters through the front and side doors is not a matter of discussion at this time. We will assume

that it is satisfactory because hospitals have been satisfied with this product for many years. An incident that occurred in southwestern Michigan on the completion of a modern community hospital several years ago serves to demonstrate other vital influences on our thinking in regard to the obligation of hospitals to set up and maintain their own standards.

In this hospital, just being organized, an osteopath applied for membership on the staff. The new board of trustees reasoned that he had a perfect right to practice in the institution because it was a tax-supported institution and the osteopath was a taxpayer and well thought of in the community. For a while it looked as though the osteopath not only would get on the staff but might even get "top billing."

"Doctors Have a Union, Too"

Not until the new administrator arrived could the trustees see the light of day. He told them that the osteopath could not be a member of the hospital staff because the hospital would not be approved by the American College of Surgeons if he were a member. Then the chairman of the board, who was an industrialist, said, "Oh, I see, you doctors have a union, too!" Yes, this was the answer.

The doctors have a union, but the several thousand men and women who direct the affairs of American voluntary hospitals have no union. In fact, they do not even write the standards for hospital administration. These standards are written by men who have never operated a hospital.

The survey made by Procurement and Assignment Service of doctors in rural areas in the South at the outbreak of the war showed the exact reason why young doctors did not locate in these areas. The reason is that we have practically no approved internships in our rural hospitals. Is it, therefore, difficult to understand why the average age of the physician in the state of Mississippi in 1941 was more than 50 years when we know that Mississippi had exactly no hospitals approved for training interns by the Council on Medical Education and Hospitals of the A.M.A.?

In 1944 Alabama had 31 interns and residents in approved hospitals; Florida, 26; Georgia, 58; Mississippi, 0; North Carolina, 76; South Carolina, 30, and Tennessee, 86. This makes a grand total of 307 potential doctors for an area of 20,000,000 population.

The two problems, first, the process of furnishing an adequate number of hospital administrators and, second, the necessity for furnishing this area with potential physicians, are mentioned together because it is my contention that if the first problem is solved, by voluntary methods, it will build up the standards of hospitals in this area so that enough institutions will be approved to solve the second problem satisfactorily.

Therefore, I propose that the greatest need of the rural hospital is an organized process of training individuals to direct hospitals. I believe that such a plan can be operated with little expense and with gratifying results. It would seem that to obtain maximum results it would be necessary to organize a training program in connection with several large university hospitals that would offer a period of rotating administrative internships.

Just for illustrative purposes assume that we could use five large institutions in the Southeast for training. The administrative intern would be assigned to duties prescribed by the hospital for approximately nine months. In this period he would learn the field or the general organization of the larger institution. At the end of this time the student would be sent for a second period of training, lasting from three to five months, to a teaching center that would provide lecturers in hospital administration. All the administrative interns would thereby be given theory, lecture and seminar training in one place.

After this second stage in the education of our proposed hospital administrator, we would select some 10 or 20 hospitals in each state in which the student would again serve a more advanced internship. The complete period of training would be some twenty-four to thirty months.

A centralized placement service would endeavor properly to locate each administrative intern in the third stage of his education and be responsible for his final placement at the end of the prescribed training. The institutions using the administrative intern would benefit by having at their disposal an individual keenly interested in his organization and willing to return good work for good training.

It is quite likely that an institution of from 300 to 500 beds could use six or eight administrative interns. By rotating through the admitting office, business office, purchasing department and out-patient clinic, and by spending shorter periods studying the administrative problems of the x-ray, laboratory, physical therapy, dietary, housekeeping, central supply, linen and engineering departments, the prospective hospital superintendent would have the advantage of learning under well-organized and trained department heads.

The three stages of the proposed process of education of hospital administrators are, to summarize, (1) a period of apprentice internship in which the objective is to acquaint the student with the general organization and functions of a hospital and to determine his ability to accept, after educational training, a responsible position in the field; (2) an intensified period of training by lecture, seminar, field problems and special research problems, and (3) advanced administrative duty in the various departments.

After such training the administrative intern should be capable of serving as administrative assistant in some medium or large-sized institution or of becoming administrator of a small hospital.

Hospitals Must Do the Job

The challenge of training the administrators of our hospitals is one that can be accepted only by the hospitals themselves. Higher education as a process cannot do the job alone any more than the medical colleges can train doctors without associated hospitals. If we ever expect to procure an adequate medical care program for the rural areas of America we can make no better beginning than by training those who will ultimately direct and set the standards for these institutions.

The development of high standards for rural hospitals through planned education and training of hospital administrators is one way in which rural areas can attract young doctors and maintain a standard of medical care comparable to that now enjoyed by our centralized urban systems.

ALCOHOLIC ANONYMOUS

A New Partner for Hospitals

MARTY MANN
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National Committee for
Education on Alcoholism
New York City

THERE is one point, apart from the "Twelve Steps" that form the basis of the Alcoholics Anonymous program, on which all A. A. groups everywhere are agreed: they want and need the cooperation of hospitals.

In turn, these groups believe that their efforts can be of great assistance to hospitals that accept alcoholics, whether they do this intentionally or unintentionally. It is the purpose of this article to make some explanations and offer some suggestions, which it is hoped will stimulate such cooperation and help it to be fruitful for both hospitals and A. A. groups.

Few Understand the Principles

Alcoholics Anonymous and its work have received a great deal of notice in the past few years. Most people know a little about it, some know a great deal. Nevertheless, it is surprising how few understand the exact manner of its working. Many are aware that its membership is made up of recovered alcoholics, even that they are banded together to help themselves and one another gain and maintain sobriety. But the methods of doing this, and the ways and means by which they help other alcoholics, are too often shrouded in misapprehension.

This is neither the time nor the place to go into the fundamentals of A. A. Its literature, explaining the program fully, may be had for the asking. (Write Box 459, Grand Central Annex, New York 17, N. Y.) Some broad facts about A. A. are, however, very much in order.

Alcoholics Anonymous, as we know it today, started with the meeting of two alcoholics, one sober and the other desiring sobriety, in June 1935. The first was able to help the second. Together they helped many more and the first A. A. group came into existence. That group, incidentally, was greatly aided in its efficient functioning and growth by the fact that the No. 2 man (A. A. calls him the co-founder) was a doctor with hospital connections, who achieved excellent cooperation from a local hospital at an early date.

Their only publicity in those days was word-of-mouth, yet by 1938 there were two groups with nearly a hundred members. Out of their experience came the precise formulation of the "Twelve Steps" and the book "Alcoholics Anonymous"; with its publication in April 1939 the real growth of A. A. began. Today there are more than 20,000 members, sober productive citizens who were once considered "hopeless drunks" by all who knew them. They are banded together in some 530 A. A. groups, mostly in the United States, but spreading rapidly in Canada and Hawaii and starting in Australia and New Zealand.

Favorable publicity has greatly helped this growth. So has the increasing recognition given by the medical profession (including psychiatry) and the clergy. But most of all the growth is the direct result of the twelfth step in the program which all A. A. members practice. It tells us to "carry this message to alcoholics." In other words, somehow to find alcoholics who need *and want* help, to work with them, to pass on what we have learned in an effort to help them get well as we have done.

It will be noted that I have used the words "we" and "us" in speaking of the twelfth step. I myself am a member of Alcoholics Anonymous, and I owe my recovery from severe and protracted alcoholism to my entry into the New York group of A. A., where I was sent by my psychiatrist in April 1939. Like other members, helping alcoholics who wanted help became my avocation (we believe it is our salvation, too) and it has remained so. In my case it so happens that educating the general public about alcoholism is my vocation as well, but that is a rare case. A. A. members generally return to the work or profession they engaged in before drinking caught up with them and work with alcoholics in their spare time.

Yet in spite of this avocational nature of the work done by A. A., a phenomenal growth has taken place. It seems important to note this fact and to suggest that there is a reason for it: the ease with which one alcoholic (recovered and sober) can approach, interest and convince another alcoholic who is still actively suffering from alcoholism.

A. A. Member "Has Been There"

The A. A. member is in a position which no one else who has been trying to help the patient, neither family, friends, physician nor hospital worker, can approximate: he has been there, has been right where the patient is now . . . and has recovered. Just the appearance of a clear-eyed sober individual who can easily prove that he, too, has been "through the mill" is a living symbol of hope, and part of the battle has been won.

There is a further reason for the constant and ever increasing growth of A. A. to be found in the urgent desire to help others that springs up in the newly rescued member. To a greater or lesser extent that desire to help others afflicted as we once were remains in all of us, but it is particularly strong in the first year or two of recovery. It should be emphasized that the twelfth step, like all the other 11, is never presented as a "must," and that they are all taken at a different pace and with different emphasis by individual members.

The A. A. program, in short, is highly individualized and is a matter

of individual interpretation by those who adhere to it. Nevertheless, in certain important fundamentals we find that we all think pretty much alike and do things connected with A. A. in a very similar way.

For instance, last year during my lecture tours for the National Committee for Education on Alcoholism, I visited 22 cities all over the country. In each one I met and talked with the local A. A. group, and everywhere I found the same anxiety to establish a basis for cooperation with hospitals. In some cases they had such cooperation but they always needed more, either more beds or more hospitals. In some cases they had none. The A. A. groups have two reasons for wanting the cooperation of hospitals:

1. They need prospects to work on (remember the practice of the twelfth step helps keep the members sober) and they would prefer to see those prospects after medical care has brought them out of the acute phases of their alcoholism.

2. They need hospital facilities to which they can refer those cases in an acute state for physical treatment before they can hope to talk A. A. to them.

Will Hospitals Cooperate?

It would seem established that A. A. groups are eager and willing to extend their work within hospital walls. But are hospitals willing to let them? Some are. Dr. Sam Parker of Kings County Hospital, Brooklyn, N. Y., writes as follows:

"Experience has proved that A. A. is an invaluable aid in rehabilitation of hospitalized alcoholics. All hospitals should be encouraged to develop wider cooperation with A. A. in planned programs of handling alcoholics. To avoid disappointments and friction, both A. A. and physicians should understand that such a program must be based upon definite objectives in order to achieve some success.

"The hospital, on the one hand, must not make the error of exploiting A. A. to get rid of its cases indiscriminately, and A. A. members, on the other hand, should not . . . assume a missionary responsibility for any kind of alcoholic between four walls. The experience of A. A. has demonstrated that the alcoholic must have something to work with in order to make progress.

"Medical experience can teach us that there must be certain criteria in the choice of hospital material for successful cooperation with A. A. . . . Medical science can be especially effective in the treatment of the physical complication of alcoholism, where A. A. is impotent. Thus, A. A. should be guided by medical opinion on this point and the hospital should exhaust its resources in the medical care of the alcoholic before considering him as a prospective referral to A. A."

When the hospitals are willing, there are many forms of cooperation in use. In some that have alcoholic wards, A. A. members are allowed to visit at certain hours, usually consulting with the doctor or charge nurse on which patients they should talk to. This practice is frequently extended to close cooperation with the social service departments, and even to an influence on admitting policies.

Groups Conduct Own Meeting

There are voluntary hospitals that maintain close contact with A. A. through doctors who place their alcoholic patients there and there are other voluntary hospitals that take alcoholics only when referred by A. A., after which the A. A. group follows up its own referrals. In state hospitals, with long-term patients, it has been possible and successful in many instances to establish A. A. groups within the hospital. These groups conduct their own regular meetings at which members from outside groups often attend and speak.

All of these methods of cooperation are possible and all have had some measure of success. One need only ask what would have happened to many of these alcoholic patients had there not been such cooperation. A roar from among the ranks of recovered Alcoholics Anonymous members would answer that question. Many of them had been hospitalized countless times with only temporary relief from their malady until, on one of those hospital trips, they encountered A. A. Now they visit others in hospitals.

All of these methods, however, would fail without the interest, the patience, the tolerance and the constant cooperation of hospital administrators, doctors, nurses and hospital workers. They all need to become acquainted with at least some of the members of their nearest A. A. group. They need to understand that these people are motivated by an honest desire to be of help, that they will give unsparingly of their time and of themselves, asking no favors in return save an opportunity to help again or, at most, the favor of getting someone who needs medical care into the hospital. And they need to look upon even their most unpleasant alcoholic patients as people who, barring mental or physical complications, *can* get well and may be able to do so with the aid of A. A.

Finally, in discussing A. A. groups and how they can work with established organizations, it is important to note well the implications of the first sentence in this article: that beyond the "Twelve Steps" and their application, there is not necessarily complete agreement among the 530-odd A. A. groups now in existence on matters of local procedure and technic.

Alcoholics Anonymous is not an organization in the usual sense; it is a fellowship of individual—and individualistic—alcoholics. It does not have staffs of paid workers. It does not even have lists of accredited workers who, alone among the membership, are assigned to make outside contacts. It often does have, in some groups, elected committees to deal with specific phases of the work, but their personnel changes from time to time.

Each Unit Is Autonomous

In most groups the hardest workers among the newcomers and in hospitals will be the newer members, those in their first and second year. And they're likely to do a better job than the older members at initiating a prospect, perhaps because of their very closeness to the problem. However, not even any of these statements has universal application, for each A. A. group is an autonomous unit and handles its local affairs in its own way.

Nevertheless, despite what may seem the handicaps of such a system, or lack of system, to hospital administrators and others used to dealing with more conventional organizations, A. A. still has more to offer in the way of concrete assistance to alcoholics and those who deal with them than has any other organization now extant.

PETER ARAKELIAN
Newton, Mass.

Aptitude Tests put the right man into the right job

DO YOU fill jobs or do you select employes to meet job requirements? During the war you probably were satisfied to fill jobs, to get people to work without much regard to efficiency or cost. The labor market after a period of readjustment will show a normal relationship between supply and demand. "Bidding" for available labor will disappear. Once again employes can be attracted to jobs without artificial high pay incentives.

This change offers no value to the employer who continues to hire individuals, try them, keep them or fire them depending on "how they work out." A more objective employment pattern is necessary for economical operation of any organization.

The two main factors in this pattern are: (1) well-defined job requirements or job specifications and (2) sound technics for selecting persons to meet job requirements. Aptitude testing is a vehicle which can take most of the guesswork from employe selection.

Strive for Similar Goals

Scientific and humanly sympathetic procedures in the selection of employes are desirable factors in personnel relations. The process of selection is one in which management and worker strive for similar results. The worker seeks the opportunity for more than just an adequate livelihood. He wants to gain that livelihood from labors that are reasonably interesting to him, have some significance and yield some satisfaction in the doing. The management's goal is not merely to get enough "hands" to do the work of the organization; it wants to receive cooperation that will be continuous, earnest and intelligent.

Positions requiring a minimum of skill occur in practically every hospital. The duties attached to such positions are to a considerable extent alike. The tests derived from this study are particularly designed, however, for orderlies and ward helpers.

The functions of these workers may be defined as follows: under immediate supervision to perform duties that do not require professional training or education in connection with the care of patients, and otherwise to assist the graduate nurses in the performance of their duties and to do related work as required.

The minimum qualifications are common school education, high school graduation preferred, and ability to understand and follow directions. Additional desirable qualifications are an even temperament, patience, firmness, cheerfulness, cleanliness, good physical condition, strength and endurance. Experience that can be transferred from other vocations is always advantageous.

Our preparation of written tests at the New Haven Hospital for use in selecting subsidiary workers was limited by two fixed conditions. Since the wages paid to these employes are comparatively low, the persons attracted are not of high mental caliber. This fact necessitated designing tests feasible for the use of such persons. Also, since we wanted the tests to be feasible in small institutions as well as in large ones that have personnel directors and departmental assistants, it was necessary to make them easy to administer as well as easy to take. With this situation in mind, the following specifications were adopted as a working basis and as far as possible the tests were constructed to meet these requirements.

1. The tests should be designed for individuals whose education has been limited to grade school level. They obviously must be easily understood and completed.
2. Testing for intelligence or schooling must be avoided. The search is for aptitude.
3. Since the occupation has no place as a skilled art or trade and hence will attract both new and experienced workers, highly specialized trade tests involving duties or functions of the job cannot be used.
4. Because there is no need for persons with literary ability, the tests should require as little writing as possible. Short answer forms will be adopted.
5. There should be a close association between the tests and the job itself so that the tests will appear practical to the applicant.
6. The amount of time required to take the tests should be as small as possible without interfering with testing efficiency and reliability.
7. The amount of time required to administer the tests should also be small so that little supervision by an examiner is needed. If possible, they should be self-administering.
8. The tests should be adaptable for use by either individuals or groups.
9. They should be designed to permit rapid and uniform scoring so that any clerical worker can correct them.

SUBJECTS

The results of tests given to a total of 74 subjects were used in this study. Of this number, 37 were males and 37 were females. The age range was from 18 to 55 for both sexes with concentration on the 20 to 30 age level. A survey of the backgrounds of the subjects based on personal data ob-

The author wishes to express his indebtedness to J. A. Hamilton, director, and to the administrative staff of the New Haven Hospital, New Haven, Conn., for cooperation and assistance in this study which was made in 1939-40.

Photograph, Courtesy "Hygeia"

Aptitude tests must be easily understood and completed with little effort.

tained from them revealed no exception from the generalized statement that the group was representative of an average cross section of persons holding or seeking employment as hospital subsidiary workers. Specifically, the males were employed as orderlies, the females as ward helpers in the nursing department of New Haven Hospital.

Since preliminary investigation showed no specific difference in test performance that might be attributed to age, sex, education or marital status, the results of the 74 subjects were combined as a basis for this investigation.

PROCEDURE

1. Analysis of Occupational Behavior. The first step in the construction of a battery of aptitude tests was to make a thorough psychological analysis of the vocation in question, in this case that of orderly and ward helper. The purpose of this analysis was to identify as accurately as possible the traits or characteristics of human behavior that lead to success or failure in this vocation.

The analysis was made in three stages. At the outset, an ordinary job analysis was carried out which was logical rather than psychological in nature in that the result desired was a detailed and comprehensive list of the various part-activities of which the occupation in question is made up.

After this list of duties was prepared, it was submitted to the executive division of the nursing service, a group composed of director, two assistant directors, 12 nursing supervisors, 30 head nurses and 33 assistant head nurses.

They were asked to denote the part-activities of the occupation under consideration in which the more efficient workers were chiefly superior to the less efficient.

In other words, some of the part-activities or duties required no special degree of skill and could be performed equally well by all workers. In other duties, however, certain workers met the greater demand for ability or skill with adequacy while others were taxed or even failed to maintain the desired standard. Completion of the second stage, therefore, yielded a sub-list of part-activities that were correlative with superior ability.

In the third stage this sub-list of critical part-activities was analyzed to discover what traits of intelligence, capacity and temperament combine to produce efficiency in these activities. In order that this analysis would be efficient and objective, a job psychograph was prepared and submitted to the nursing group previously described. It was asked to rate the 34 qualities to determine which were deemed essential for success in the vocation of orderly or ward helper.

The pivotal traits about which the test battery should be centered were found to be accuracy, carefulness, thoroughness, efficiency, integrity, cleanliness and orderliness. Certain qualities, such as cooperation and cleanliness of work, are difficult to test in an efficient objective manner and, at best, can appear as parts of other objective trait-complexes. Traits of personality and temperament were measured during the personal interview. The distinctions between many of the qualities listed are not absolutely clear cut; however, they are not simple or elementary in nature and cannot be defined as such.

2. Assembling the Preliminary Test Battery. An adequate psychological analysis of the occupational behavior having been completed, it became necessary to assemble a series of known and newly devised tests that would measure the traits revealed. Fitting tests to aptitudes involves a considerable element of trial and error. Therefore, two or three times as many tests as are intended for final use must be included in the preliminary test battery.

Regardless of the care taken in the aptitude analysis and test selection, many tests for one reason or another will be found lacking in forecasting value. Accordingly, there was assembled a series of 13 tests, all of the pencil-and-paper variety, which could be given to a large group of subjects at one time or individually.

3. Administration of the Preliminary Test Battery. A series of 13 tests having been assembled, the next procedure was to "test the tests," for in order to be incorporated into the final test battery, proof of their prognostic potency was necessary.

The trial group of subjects has been described previously as being sufficient in size, representative of the general population in this type of work and amenable to fairly accurate measurement on the job as a basis for actual aptitude criterion.

The order of the tests was arranged to reduce the likelihood of continuation from the activity of one type of test into another, thus causing interference of one activity by the other. The first test in the series was of such a nature as to reduce excitement or timidity on the part of the subjects. Its simplicity was deemed beneficial in counteracting emotional tension. Complete explanation of the purpose of the tests and encouraging

remarks by the director of the hospital aided in establishing the proper attitude. The desired competitive spirit was evoked also in the same manner. The tests were administered according to the strictest rules as regards proper environment, proctoring and timing.

4. The Criterion Score. One of the most important factors in the test battery construction is a reliable quantitative criterion of actual aptitude. The entire project is worthless without an adequate criterion. Without this quantitative expression of the subject's vocational proficiency, there remains no value to which tests of aptitude can be compared.

Since the occupational activity being studied cannot be measured in terms of articles produced per day, or time consumed per article, as might be the case in bricklaying or in running the 100 yard dash, it was necessary to obtain the criterion scores by use of a graphic rating scale specially devised for the purpose.

The rating scale was the best technic because the employes were distributed in the many divisions of the hospital and consequently were under the supervision of many different individuals. This meant that no fair ranking could be obtained directly because each supervisory worker was not familiar with each subsidiary worker. Two ratings were obtained on each employe from two independent raters. The average of the ratings was found and used as a basis for ranking them from highest to lowest.

RESULTS

5. Final Aptitude Battery. With a complete set of scores on the tests of the preliminary battery and a complete set of criterion scores available, it became possible to determine which of the tests of the preliminary series were worthy of retention. This worthiness depended on whether a particular test contributed enough to the forecasting efficiency of the test battery as a whole to repay the cost incidental to its use.

The contributory value of a test to the forecasting efficiency of a battery was based upon two factors: (1) its relationship to the criterion and (2) its relation to the other tests in the battery. In other words, the correlation between the tests and the criterion should be as large as possible, whereas intercorrelations between the individual tests should be as small as possible.

If these conditions are met, the tests will have proved that they measure the aptitudes for which they were designed and duplication of effort among the various tests will have been minimized. The statistical method used was the product—moment correlation co-efficient devised by Karl Pearson.

After careful comparison of the relative merits of the tests, five of the preliminary 13 were selected for the final battery.

This series of five tests was combined into a battery which required twenty-five minutes to complete and was self-administering beyond timing from the "start" to "stop" points of the twenty-five minute period. The tests were: (1) accuracy of detail, (2) integrity, (3) mental alertness, (4) carefulness and (5) thoroughness.

Combined with an adequate personnel history showing education, experience and past performance, in addition to a thorough interview, the test results will make employe selection a systematic and objective technic rather than a guessing contest.

Actual experience with the tests was limited by the onset of the war and subsequent chaotic conditions of the labor market. Selection is possible and testing is feasible when a sufficient labor supply exists from which to select employes. It is possible that more experience will yield suggestions for changes or refinements in the tests.

Standardized Technics

serve the patient best

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THE word "standardization" is anathema to most physicians. The surgeon particularly is inclined to be an individualist and to have developed from study and experience a technic which is as much a part of himself as are his clothes. Perhaps this is best, for to attempt to regiment the thinking and actions of physicians would probably not be to the best interests of the patient.

On the other hand, the task of teaching nurses to practice as many technics as there are surgeons in the hospital would encourage errors.

In the voluntary hospital an attempt should be made to obtain standardization of preoperative and postoperative technics because, first of all, such standardization best serves the patient. Sometimes surgeons do not seem to understand that the establishment of aseptic routines is a difficult problem because it requires the instruction and perpetual drilling of a changing group of nurses.

It is not safe for a surgeon on short notice to alter times of scrubbing, the type of antiseptics or the shapes and sizes of surgical packs without first having presented the matter to the head of the school of nursing so that technic books can be amended and the classroom instruction of nurses carried out. Such abrupt changes should not be permitted. The danger of error is multiplied if word of mouth alteration in details of technic is permitted. The same principle applies to the instruction of interns.

Standardization of technics saves time, money and supplies. In some institutions multiple types and strengths of antiseptics are employed so as to conform to the special wish or whim of each individual surgeon. It may matter little whether an antiseptic is 2 per cent or 2¾ per cent in strength. The hospital has a right and a duty to require the surgical staff to decide as to the types and strengths of antiseptics to be used for skin sterilization.

There is no general agreement on such an apparently minor matter as the kind of laxative to be prescribed before operation or as to whether the primary preparation of the skin shall be performed in the ward or on the operating table. Moreover, no general agreement has been reached as to who shall be responsible for preoperative preparation. In some hospitals nurses from the operating room are responsible for this work. This plan has a great deal to recommend it.

There is another item that affects institutional economy, namely, the damage done to hospital linens by certain dyes commonly employed in the operating room. It is probable that the purchase price of such antiseptics sinks into insignificance when compared with the permanent damaging of costly linens by staining. Unless the hospital has a right to express some opinion on such matters it has no way to protect itself from extravagances that are committed in the operating room.

Accepted but Not Practiced

There are some principles which are generally accepted but still for some reason are not universally practiced. Obviously, preoperative study is highly important and ample time should be given for this purpose, except in true emergencies. The hospital may well rule that, except in an emergency, no major operation may be performed on the day on which the patient is admitted. This regulation is sometimes difficult to enforce but exceptions should be most difficult to obtain. Inexperience and lack of thoughtful approach to a diagnosis will militate against the chance of the patient for speedy recovery.

Definite rules should be laid down as to the time for the collection of laboratory specimens from preoperative patients. As an example, it can well be required that all blood and urine specimens from patients to be operated upon before noon on the following day shall be in the laboratory before the day force concludes its work on the previous day. If afternoon operations are to be done, specimens may be sent to the laboratory at 9 a.m. on the same day for final check.

Most surgical groups are agreed that no case should be sent to the operating room for a major operation until the following procedures have been performed and recorded on the chart: a urinalysis, a full blood count, perhaps an electrocardiograph, a blood pressure and a blood urea, if albumin or casts are found in the urine. This list of laboratory requirements will vary in the individual hospital but a definite list should be set down.

In some hospitals it has been ruled that no major surgical operation can be performed without a consultation having been held and that the result of this consultation shall be inscribed upon the chart.

It should be routine for an operation to be scheduled one or more days in advance, for the properly executed consent to be on file and for a clergyman and the family doctor to be notified in sufficient time for them to visit the patient in his own room.

The rules governing the preparation of the patient by the nurse cannot be too detailed. The location and extent of shaving, the clothing of the patient, the method of transportation, the cleansing of the mouth and, above all, the psychic preparation of the patient are important matters. The difference between an ordinary hospital and one of special distinction is often manifested by the method in which the patient is psychically prepared for his ordeal.

Such matters as the technic for catheterization and the cleansing of the bowel in rectal operations should be fully described in the instruction book which is the guide for both interns and nurses.

A few matters affecting postoperative standardization must be mentioned for the sake of completeness. The responsibility of the anesthetist should not end until the patient has been safely placed in his own bed and the special duty or ward nurse has taken over. In some hospitals the anesthetist is excused the moment the dressings are in place. Occasionally accidents, such as asphyxia from tongue swallowing or the inhalation of vomitus, have occurred before the patient reaches his room or ward.

Instructions Should Be Written

Postoperative instructions should be written after the patient returns to the ward and not before. Specific directions should be found in the technic book as to the signs of hemorrhage, as to feeding, laxatives, dressings and the removal of sutures. Fortunately, postoperative technics do not vary as greatly as do preoperative preparations.

Now it will be accepted by most persons that standardization is advisable. How can it be done? Because this requires staff action, a willingness to cooperate for the benefit of the hospital and the patient must first exist. No surgeon must contend that his method is the only correct one. There must be a healthy spirit of give and take. The staff committee in charge must exhibit a thoroughness that reflects attention to the smallest detail.

While standards are being drawn up, a conference with the operating room supervisor would seem advisable. Approval by the medical board of the standards then makes them law. All must now adhere to them.

Hospital personnel and professional leaders are more easily persuaded to adopt uniform practices when they are printed and placed in the hands of all who should know the details. Frequent conferences and timely revisions may lead to greater common interest in standardized procedures.

Chronic Disease

From a Patient's Point of View

In her concluding article the author describes a village settlement for the chronically ill

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FOR those who feel that there should be a way to combine the types of institutions for the care of the handicapped described in the preceding sections of this article there is another suggestion. That is for a village settlement which could combine the best features of rural and urban life. It isn't just a dream, as there have been experiments made along this line.

In England the Varrier-Jones Village Settlement was established to enable arrested tuberculous patients to resume family life and limited work under better surroundings than were possible in their congested city homes. Several village industries provided employment at regular wages. Sanitary living conditions and periodic checkups maintained family and the erstwhile patient's health.

At present both our Army and Navy medical services are demonstrating speedier rehabilitation in health resort centers. Although the hospital atmosphere is eliminated by the use of clubhouses and hotels remodeled for this purpose, both physical and occupational therapy is continued and an effort is made to prepare the veteran for future employment.

It seems reasonable to suggest that an adaptation of these programs could provide a larger number of the handicapped with more normal living conditions.

Adapted for Family Living

Housing units should be provided to suit the needs of family groups, with dormitories for those requiring single rooms and a building for those needing nursing care. Thus, many who find city transportation facilities dangerous and many wheel chair occupants could find employment in the settlement's industries.

The industries in such a settlement would be planned to accommodate handicapped workers. With the decentralizing of many industries it should be possible to establish healthful living conditions in outlying sections of city or state. For the disabled head of a family to be able to furnish such a home would remove a load of insecurity and make him a better workman. Also, the families would add to the able-bodied population.

I am not suggesting that all handicapped persons would care to locate permanently in such a settlement but it could also serve as a rehabilitation center for the recently disabled. With a medical clinic and occupational therapists, the hospital patient could be referred to such a center where he could be trained under actual working conditions. The home-bound could also come for short periods for treatment or to learn new activities suitable for home conditions. It might be cheaper to maintain instructors at such a center than to give bedside instruction to widely scattered individuals. Also, the isolated handicapped person would benefit by this experience of seeing and knowing other cripples at work.

Combining the best features of rural and urban life would bring advantages now possible only to the most active of the city group. One of the well-known handicapped leaders in Chicago recently mentioned that he could not travel safely in winter time. How independent he could be away from slippery curbs, street cars and elevated trains.

Truck gardening, dairy farming and kindred activities could absorb those interested in and capable of such pursuits. Such outdoor jobs would be recommended to many for health reasons and these activities would also provide fresh produce at lower prices for indoor workers.

Business opportunities would be evident to those with experience in servicing this community. Regular employment would provide most of the residents with funds to purchase goods from local stores. It would be only natural that small local stores be established by the handicapped themselves.

It Has Been Done

If this seems visionary and impractical, let us consider some of the successful ventures that have been undertaken by the handicapped. The Institute for the Crippled and Disabled in New York is the best known. It combines training for industrial employment with regular sheltered workshops for those who cannot do competitive work with normal people. Since only those who can travel unattended are admitted, many must be turned away. But in a village settlement, many of the jobs they find successful could be utilized to employ all types.

With far more limited equipment and opportunity, the Borrowed Timers of California have maintained a self-supporting community under cooperative management.

Another group concentrating on one specialty is the Necktie Manufacturers of St. Louis. It gives employment to many who could find no jobs elsewhere. Incorporated as a nonprofit firm, its building is now debt-free and excess profits are donated to other agencies for the handicapped.

These are but straws in the wind indicating both the desire for greater independence and the possibility of achieving it. If experimental communities could be started under com-

petent supervision, they would soon demonstrate their worth.

As possible industries I suggest manufacturing small plastic and wooden items, the assembling of parts, which is often done in outlying factories, weaving, printing and making toys and greeting cards. I select these because they have been successfully done by those who are handicapped; also they offer a wide variety of activities suited to different degrees of bodily impairment and scope for both the routine performer and the creative artist. Merchandising and office jobs would give outlets to those with business ability. Individuals of my acquaintance possess all of these qualifications which lie dormant for lack of opportunity.

As a more concrete illustration I use my own business of making greeting cards. In my experience in teaching others by mail I have learned much that would apply to any group of handicapped individuals. Those who criticize the shut-in for doing so little often fail to realize the difficulties of a one-man business. The first is to find, make or design the particular item that will have wide enough appeal to draw customers in person or by mail. To make greeting cards one must be artist, printer, purchasing agent and manufacturer, and to sell them, he must also be advertiser, bookkeeper and salesman. This is a large order for the able-bodied! Not many can qualify and make an adequate living in such diverse activities. Therefore they give up in discouragement or are satisfied with an inferior product and pin-money returns.

Each Could Do His Best Work

However if abilities could be pooled and each individual could do the work most satisfying it would be a different story. The creative artist with a flair for designing best sellers could concentrate on that aspect and no longer be irked by the need to make large quantities of one design. The neat copyist could do the quantity orders that were suited to his skill. In this way physical needs and artistic ability could be given consideration.

Combining commercial art processes in printing and engraving with hand work would greatly increase the variety of designs and speed of workmanship, thereby bringing larger income. There is always a demand for unique hand work and this is a specialty in which the handicapped artist could excel.

There are also the routine jobs suitable for the severely crippled or those able to work but a few hours a day, such as sorting and packaging orders, cutting, pasting, tinting, stapling and wrapping packages. And as a by-product there could be the philatelic values in unusual stamps culled from the quantities collected.

The greeting card salesmen of the nation are frequently handicapped. Merchandising the goods manufactured in our hypothetical community would add to their stock also.

Extension of the benefits of larger purchasing of material would assist the home-bound worker, too, and a concerted effort in this larger group would tend to create better products. It must be the concern of all these settlement industries to establish and maintain good standards of workmanship. Any appeal to sympathy in advertising would only be a detriment.

Working in a business with high standards and good wages would be a boon to many who are now shut in, a burden to themselves, their families and the community. One seldom mentioned advantage is regular hours with leisure for recreation and companionship. The one-man business so often means being continually surrounded by one's work. The self-employed individual finds it difficult to say "no" to importunate customers and often works too long hours. In this one-man sweat shop disability may be increased.

On the medical front there are obvious advantages in the settlement plan. Research could be carried further than hospital records permit, with adequate follow-up procedures in all types of crippling conditions. A center of this kind would also be an excellent training ground for student physical therapists, orthopedic and public health nurses, medical students and occupational therapists. This would help increase medical knowledge and further preventive measures in public health agencies.

"It sounds Utopian," I hear you say. I am not envisioning any paradise, for our disabled population has all the faults and virtues of any community. Administration should be no more difficult than in any institutional setup. With more opportunities for self-expression, work and recreation it may actually be much easier.

The highly important financial considerations would require greater research, of course. It is not essential to the final goal that all units of such a settlement be established at once. Undoubtedly, it would grow as needs are evidenced and funds are provided, as general hospitals have developed.

Taking the long view of expense, I question whether it would be as great as for many scattered institutions. If initial capital could provide long-term, low-interest loans for family units, permanent residents could pay for their own property. Working individuals living in dormitories or apartments would pay standard rents.

It Should Be Self-Supporting

This employed group would be entitled to the same social security benefits provided in any industrial plant, and it could provide for emergencies by group hospital insurance, credit unions or savings clubs. Thus it would soon be completely self-supporting and able to pay its share in maintaining community privileges.

The greatest expense would be for the completely helpless and the partially rehabilitated who can never be entirely self-supporting. A few of these may have savings or insurance to cover an entrance fee as is customary in most custodial homes. Experience shows that these are a small minority. County welfare cases in foster homes in Illinois vary in the sums allowed for their care; they range from $1.50 to $1.75 a day at present. If counties could pay this fee for each case sent to the settlement any additional overhead could be met by (a) part-time employment if the patient's condition permitted, (b) endowment funds established for this purpose.

Accident insurance and pensions may provide sufficient funds for some cases. There will always be exceptional instances that will fit into no pattern. So, as in other departments, the financial plans would have to be flexible. One experienced social worker consulted believes that the funds for institutional care would be easily raised if the public knew the need and an organization was ready to proceed.

How Buffalo Fought "Polio"

MOIR P. TANNER
Superintendent
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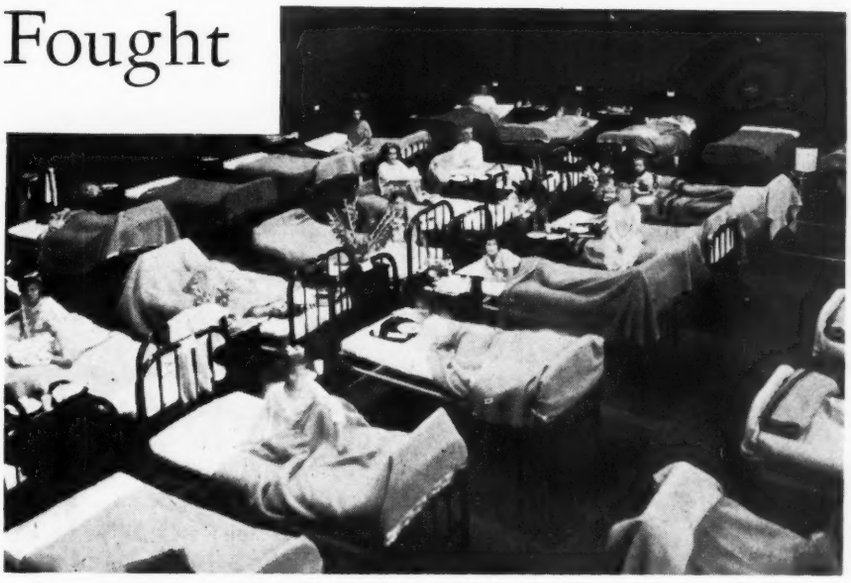

Poliomyelitis cases filled the Children's Hospital "Annex" to overflowing.

THE summer of 1944 brought to Buffalo and Erie County the largest and most serious epidemic of poliomyelitis in the history of Western New York State. The records show that there were 1072 cases in Erie County and more than 80 per cent of these were within the limits of the city of Buffalo. The epidemic started the last week in May in the small suburban community of Eden and progressed rapidly through the city of Lackawanna, which had more than 100 cases, and then into the outskirts of Buffalo.

The Children's Hospital, because of the type of service it has always rendered, was looked to for the care of the great majority of these patients. More than 70 per cent of the hospitalized cases were cared for in this hospital. There were 708 admissions and 61 of these children failed to survive their attack of poliomyelitis. More than a year after the inception of the epidemic, 85 of these patients were still under treatment.

Early in the summer it became imperative that additional facilities be provided, and the hospital was at once confronted with a tremendous problem. This was greatly relieved, however, when a public-spirited citizen generously made available to the hospital a large recreational building which has housed more than 120 patients. Here were admitted most of the cases requiring rehabilitation care, and the building has become known throughout the community as the "Children's Hospital Annex."

Personnel to care for these patients rapidly became a problem of great magnitude and the hospital turned to the Red Cross. Here were found nurse's aides, Gray Ladies, canteen workers, motor corps workers, staff assistants, all ready to help in this emergency. The parents of the patients formed volunteer groups and helped to care not only for their own children but also for other children stricken with the disease.

In the care of all patients strict isolation technic was carried out until the febrile period had passed. Most of the patients were isolated for from ten to twelve days. The contagion building was quickly filled. Other wards were emptied by discharging every possible case and were made available for acute poliomyelitis cases. The cerebral palsy department was closed and a large auditorium and a living room in the nurses' residence were converted into hospital wards. Before the summer was over the hospital was 90 per cent filled with acute poliomyelitis cases. The out-patient department was organized as an admitting unit, where doctors and nurses were on continuous duty examining and admitting all positive cases.

Attempted to Trace Disease

While parents waited for the results of the spinal puncture made on a patient, the research department of the hospital lost no time in interviewing them in an effort to determine the source of the disease and the method of spread. The department also studied the earliest cases in the hope of finding some reason for the start of the epidemic.

To face such a widespread epidemic with the existing shortage of nurses was alone a matter of the utmost concern. Too much praise cannot be given to the many nurses who came off duty in one unit only to go on duty in another; to the married nurses in the community who came to the hospital for day and night duty; to the student nurses, both in the Children's Hospital school and in affiliating schools, who worked through the epidemic with little time to themselves; to the students affiliating with other schools who came back at night, not always to care for patients but to do the countless other necessary tasks; to the student nurses of Deaconess Hospital in Buffalo, who volunteered for additional duty and made it possible to provide special nursing for patients confined in respirators.

Parents, nurse's aides, students and others were given instruction in the technic of applying Kenny packs, which were used almost routinely during the early stages of the disease.

Doctors came to Buffalo from other cities to study the disease and to help with the constantly increasing case load. Resident physicians at Buffalo General Hospital accepted stated hours of duty in addition to their regular hours at their own hospitals. A battery of "iron lungs" was in almost constant use for more than six months. Bulbar cases were not routinely assigned to respirators (only the cases with intercostal paralysis were treated in this manner) and the records show that 27 patients were confined to iron lungs, of whom only seven survived.

The procurement of equipment was a matter of immediate and ma-

jor importance. It is one thing to have a census of 250 patients and quite a different matter when, suddenly, there are more than 450 patients, three fourths of whom are suffering from poliomyelitis. A local bed manufacturer found it possible to take beds from Army and Navy orders and divert them to hospital use. A mattress factory worked day and night to keep the hospital supplied. The building which had been lent to the hospital had to have heating and ventilating equipment, and here again the government stepped in to make this equipment available directly from war orders.

There was hardly a day or night that city firemen were not at the hospital working diligently to install this equipment. They did a remarkable job and they have, and deserve, the gratitude of the entire community.

Unsolicited checks came in from organizations, industries and individuals who realized that the hospital was faced with a financial problem of major proportions. Such contributions not only helped to solve acute financial problems, but also brought moral support.

Paralysis Foundation Helped

The Buffalo and Erie County Chapter of the National Foundation for Infantile Paralysis has stood at the shoulder of the hospital. It made funds available to take care of additional equipment and to pay for the care of the patients. Furthermore, the chapter realized the hospital's problem of caring for patients at a rate less than the cost of that care and it is now making available additional funds. Without this help the Children's Hospital could not possibly have done the job that the community looked to it to accomplish.

Laundry workers, kitchen help, maintenance men, all were quick to sense the responsibilities that they, as hospital workers, must assume. Vacations and days off were ignored and the hospital continued to give these patients the care they so desperately needed.

While these young victims of poliomyelitis are receiving treatment in the hospital annex, they are learning community life and every effort is constantly being made to provide them with the same daily routine that they would have in their own home communities. This has resulted in the transformation of a hospital into a community organization.

The children have school daily and are taught by teachers furnished by the Buffalo Department of Education. Boys have classes in the morning and girls in the afternoon. The beds are arranged in groups to designate the different grades; hence, each child is near other children of his own age and in the same school grade.

The spiritual welfare of these young people has by no means been neglected and, as any community is incomplete without its churches, this little community has religious services of the Protestant and Catholic faiths each Sunday. These services are conducted by the clergy of the city and are attended by members of the hospital staff, as well as by the patients.

Weekly motion pictures are shown through the courtesy of the Variety Club, a local theatrical organization. Other theatricals are also a part of their daily lives. It is seldom that a prominent person in the world of motion pictures, radio, stage and sports comes to Buffalo without making a personal appearance at the annex. All that is necessary is to explain the situation to the visiting star and he never refuses to visit these patients.

Boy and Girl Scouts have their own troops, and several of the boys have learned telegraphy through their scouting courses, which, in some cases, has been sufficiently thorough for them to make a living by it in later life. The older girls have a charm school, which teaches them poise and deportment and proper conversation. A dancing school is also conducted, with classes each week. This has been extremely beneficial to many patients in learning to walk normally.

Many of the patients give a great deal of their time to the garden club during the summer. The girls plant and raise their own flowers and the boys have their own victory gardens in which they raise all kinds of vegetables. A student council governs this little community. The various activities of the group are planned and carried out under the direction of the council, which also deals with minor matters of discipline. The annex has its own band, composed entirely of patients, and a Glee Club functioned for a time.

In short, these young patients are being taught to live with their handicap and also with one another. They are living much the same life as they would in their homes, insofar as it is humanly possible to do so. They are being given the educational, recreational and other advantages of all American boys and girls, and there is little doubt but that these children will return to their homes having lost little of the teaching, training and experience of the average young American.

The most important part of the patients' daily life is, of course, the treatment they receive. The former squash court in the building is now the physical therapy room. This form of treatment is augmented by functional occupational therapy. Both of these treatment departments work together to obtain the best possible results in the shortest possible time.

Another 120 Cases Admitted

The 1944 epidemic did not end until late November. Yet early spring of 1945 brought even more cases to the hospital; 120 were admitted with a positive diagnosis. During the summer season the population of the Children's Hospital Annex was brought back to somewhere near the level of the previous winter. With these admissions, however, it was not necessary to open additional facilities, and all acute cases were taken care of without overtaxing the communicable disease pavilion. Nevertheless, the work that we felt might last for a year instead will continue for two years.

According to the history of epidemics, it is unusual to have as many cases as this in the year following such a large epidemic. It has been noted that these cases have less involvement than had the 1944 group. However, we have had a constant problem in obtaining adequate professional assistants.

The hospital had a remarkably revealing experience in helping to bring the many forces working in the community to its aid in the 1944 epidemic. Everyone who had a part in the work, whether that part was in caring for crippled children or doing other hospital chores, realizes that each has a place in the fight against poliomyelitis.

Let's Go Back to Basic Principles

to establish a fairer relationship between pathologists and hospitals

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Pathologist
Meadowbrook Hospital
Hempstead, N. Y.

A SET of basic principles was formulated and jointly approved by the board of trustees of the American Hospital Association and the American Society of Clinical Pathologists in 1939. The prime purpose was to guide the two groups in their mutual services to the patient and also to regulate the administrative and scientific functions shared by the hospital and the pathologist working therein.

It is to be regretted that even though these principles were given wide publicity at the time they have influenced but little the relationships of the two groups so that, at present, very slight progress in this direction has been accomplished. It is with the hope of stimulating the active adoption of these principles that this article is written.

Laboratory Services Essential

The preamble to the formulated principles states: "It is recognized that pathological and other laboratory services are essential elements in the diagnosis and treatment of disease and in its prevention and control; that a competent laboratory service under skilled direction is an essential element in the hospital; that the number of qualified pathologists is limited, and that many hospitals and communities are too small to maintain locally qualified specialists in this field."

Recognizing this difficulty of obtaining the services of the specialist in laboratory medicine, Article 3 of the joint agreement states: "If because of size or isolation of the hospital or for other reasons a qualified pathologist is not available locally, some member of the general medical staff trained in pathology or paying particular attention to the subject should be appointed in immediate charge of the department. Under these conditions a consultation service should be arranged for the department with a qualified pathologist."

At a meeting of the American Society of Clinical Pathologists and the chairman of the council on professional practice of the American Hospital Association this matter came under discussion. The pathologists decried the present practice whereby members of the hospital staff interested in surgery or medicine are appointed to serve as laboratory directors without adequate training in pathology. It was also pointed out that these individuals frequently delegate the direction of the laboratory to a technician and, furthermore, in a large number of instances no arrangements existed for a consultation service with a qualified pathologist.

From this it is readily apparent that at least one of the basic principles of the agreement between the two groups is being violated. It might be pointed out, too, that there has been a greater tendency than in the past for small hospitals to send routine laboratory material to distant centers and medical schools when local facilities already exist or could be established. It is obvious that such a procedure fails to elevate the caliber of the laboratory work performed in the small institution and fails also to add to the general knowledge that could be supplied by a well-trained clinical pathologist even though his contribution was only limited to that of a consultant.

Article 4 of the joint agreement states: "Recognition of the pathologist as a professional member of the medical staff of the hospital and as head of a hospital department is obvious." It emphasizes the need for the institutions to view the pathologist in the same light as other specialists in medicine, extending to him the same rights and privileges, such as serving on hospital boards, attending meetings of heads of services and shaping policy.

It seems obviously unsound to deny the pathologist these privileges in the professional life of the hospital simply because he is a salaried employe. On the contrary, there seems to be good reason for including him in administrative and policy-shaping matters in the institution. This is true because among the professional groups working therein the pathologist spends most of his professional life actually within the walls of the institution and, therefore, is in a better position to sense and feel the character of his environment than is the case of the busy specialist whose main contact with the institution is frequently cursory.

Must Educate the Staff

In this connection, too, it would seem timely to engage in a planned and perhaps forceful program directed at educating the medical members of the hospital staff, both general practitioner and specialist, as to the contribution that the pathologist makes in the hospital care of the patient. This need becomes obvious if one regards the interpretation of laboratory tests and tissue diagnosis as having the same weight as the medical and surgical consultations of the other staff members of the institution.

This educational attempt might with profit be directed primarily at the surgical members of the hospital staff so as to convince them as to the parity of the contribution that the pathologist makes in a given surgical

problem where both are involved. It seems proper at this time to dispel the idea that because the surgeon establishes the physician-patient relationship and the pathologist does not the responsibility of the latter is not as great. The diagnostic judgment and technical skill of the surgeon in the care of the hospital case are nearly evenly matched by that of the pathologist.

The tradition that has been deep rooted among surgeons as to their major responsibility for the life of the patient, while true in the early days of surgical practice in the home and before the high degree of efficiency of hospital care was developed, does not hold true at this time. No one, not even the surgeons, will deny that the remarkable progress made in surgical diagnosis and treatment in this country is in large measure due to the facilities provided for the surgeon by the hospital and, therefore, is almost entirely uncontrolled in this respect by his own individual effort.

Similarly, it cannot be denied that these hospital facilities, a good segment of which lies in the field of laboratory medicine, have not received proper emphasis by the surgeon, who subconsciously assumes that because he is the quarterback on the team he plays the whole game himself.

They Are All on the Team

By a proper and fair emphasis of these points the hospitals might then succeed in holding out hospital care of the patient as a cooperative enterprise and, thus, the laboratory, x-ray and anesthesia departments would then receive their proper place on the hospital team. This new view of the situation is based purely on the scientific medical care of the patient in the hospital and has no bearing on the economics of the hospital-physician-patient relationship.

It should follow, however, that if the medical profession and the hospitals recognize the real state of affairs as they now exist and admit that they are in sharp contrast to the traditional view, then the economics of the salaried medical personnel in the hospital would of necessity have to be revised so as to be more on a parity with those of the other medical members of the team who are not employed by the institution.

Article 6 of the agreement states: "The preservation of the unity of the hospital and its component departments and activities is an essential administrative principle. This principle should be maintained in respect to the laboratory department without any infringement on professional rights or professional dignity."

The principles outlined therein are clear cut and commendable, being also of practical application. It is a fact, however, that they too, in many instances, have not been observed. For example, it is generally recognized that the arrangement whereby the salaried pathologist is under direct administrative control of the hospital superintendent does not always make for efficient laboratory functioning. Many hospital superintendents are not medically trained; a large number of them are registered nurses with no extended knowledge of either medical or hospital administrative problems, and for that reason relations between the two groups often become strained, with the result that laboratory efficiency is impaired.

While it cannot be denied that the administrator must have authority in broad institutional problems, it must also be allowed that the pathologist should be given a measure of freedom in the organization and administration of his laboratory and that one of his prime functions in this respect should be the coordination of his administrative efforts with that of the institution as a whole. Such an arrangement cannot always be practically executed under the present setup for one reason or another.

A possible solution, it seems, would be to establish a buffer group composed of members of the medical staff of the hospital, whose duty it would be to aid in formulating the medical policies of the institution. With the establishment of such a group the pathologist would then be held responsible to it for all professional and economic matters.

This freedom from much unnecessary administrative control of the pathologist would, in turn, stimulate him to greater service and might well tend to make for a better economic standing of the laboratory and the pathologist himself. The experience in the past has been that institutions lacking such a functioning medical buffer group deny the pathologist any right to fruitful discussion on matters concerning the welfare of his laboratory or his own professional or economic welfare.

Moreover, it has been frequently noted that under the present arrangement of administrative control of the pathologist he cannot rightfully and with any propriety appeal to the general board of the hospital, largely because his requests for a hearing and a discussion of his problems are usually transmitted through the superintendent and are either tabled by him or, worse still, frequently presented in a light prejudicial to the problems of the laboratory or the personal problems of the pathologist.

Finances Are Local Problem

Article 7 reads: "The financial arrangement between a hospital and its pathologist should be such as will best meet the local situation since no one type of relation is applicable or suitable in all instances. The basis of financial arrangement may be salary or commission or fees or such other method or combination of methods as will meet most effectively the needs of the patients and community, of the individual hospital and of the pathologist."

This statement of principle is commendable and places the situation in a fair light, recognizing the responsibilities that each group has to the other and, above all, to the hospital patient. Unfortunately, its ideals are too frequently disregarded or even violated, with the result that a great deal of chaos exists in this field of financial arrangement. Frequently, each side clamors for more than its rightful due, impelled often by a selfish desire and with a resultant total loss of perspective.

This situation is perhaps especially acute in the smaller community hospitals. In rural communities the same pathologist frequently serves more than one hospital, and it would seem desirable for the various institutions concerned to have a unified

approach in respect to the administrative and economic problems of the laboratory.

Unfortunately, it has been the experience of pathologists that many small community hospitals, frequently because of unresolvable difficulties fostered by the inevitable human conflict of medical personalities in the group, refuse to cooperate with one another in establishing a broad and unified laboratory service for the community. If such cooperation existed, a great deal more of the time of the pathologist would be given over to basic laboratory problems rather than to the varying sets of administrative problems that each hospital provides.

Cost Could Be Reduced

Similarly, if such an arrangement existed, the cost of laboratory operation in the individual institution could be reduced by the simple expedient of allocating the performance of certain types of laboratory work to that institution best suited to the task by virtue of physical equipment and technical personnel, thus preventing duplication of effort. For example, with a group of three hospitals under the direction of one pathologist, one institution of the group could undertake to handle the more detailed and less frequently ordered chemical tests in all the hospitals, while another, in return, could serve as a center for the more detailed investigation of the bacteriological material and the third could handle the pathological problems of the group.

Each institution would share equally on a basis of more extensive and more accurate laboratory work. Such a division of effort would often render it unnecessary, because of lack of laboratory diagnostic facilities, to transfer the problem case from the small hospital to the large community or medical school hospital. This arrangement, in turn, might serve as an incentive to distribute the trained pathologists in the country more evenly, thus tending to improve the present situation in which the best trained men usually settle in the population areas where the best and largest hospitals are to be found.

This matter of economic policy toward the pathologist needs revamping and calls for the development of a future policy that is realistic and more in keeping with human relations in other areas of existence. For example, one of the principles (Article 9) of the joint agreement states in part, ". . . and the principles should be so applied that neither the hospital nor the pathologist should exploit the patient or each other."

In this connection it is to be feared that many institutions are cloaking their actual desire for accumulating laboratory profits behind the old traditions of medical practice whereby the physician is always expected to give of himself freely for the service of his fellow man. This spirit is highly commendable but should be applicable to the sick poor only.

In summary, then, what the pathologist seeks is simply good laboratory facilities and a relatively free hand in his work coupled with an economic policy similar to that governing all human enterprise, namely, a fair reward for services rendered with the added provision that, if his services are satisfactory, he should derive increasing economic returns on his professional investment in the institution. It would seem that such a policy would make for a more stable situation in the hospital laboratories in respect to the performance of both the professional and technical personnel and would lead to the development on a wider scale of the "career" pathologist in the hospital of his choice. This realistic approach to the need for improving the economic status of the pathologists is of great importance to the institutions themselves.

With the marked expansion of hospitals throughout the country and the assumption that hospital growth, based in some measure on the possibility of federal aid, will be considerably greater than in the past, it follows that the construction of new institutions will of necessity demand a larger supply of trained specialists in laboratory medicine. These obviously can only come from the ranks of the younger medical men.

In order to attract these men into the specialty there must be provided for them sufficient professional and economic incentives in the various institutions, conditions which certainly do not generally exist at this time. If the institutions give thought to this matter and attempt to review and revise the conditions under which the pathologist now functions in the hospital, then the increased advantages so provided will undoubtedly serve to attract a larger number of suitable men to the field of laboratory medicine.

Operating a Dental Service

THE dental service in the Middlesex Hospital, Middletown, Conn., is still in its formative stage although it has been active for some time. To gain admission at the present time a patient may be admitted directly to the hospital on the dental service following referral by a dental surgeon with hospital privileges.

The dental service is organized within the medical board as are other medical services and is headed by two dental surgeons each of whom takes the service for a six months' period. Both dentists are listed on the senior attending staff.

The attending dentists perform the dental treatment necessary or work in consultation with attending physicians on service patients whenever they are requested to do so. Other accredited dentists in the community also have hospital privileges and, therefore, may hospitalize dental patients for private treatment although they do not hold staff positions. The dental records are established and maintained in the same way as medical or surgical records and, upon completion of treatments, the records are filed and handled like any other admission.

In the past it has been our experience that some physicians had difficulty when referring patients for dental consultation because doctors are likely to request "the second and third left lower molars extracted" instead of a "dental consultation." Dentists like any other specialists desire the recognition due their specialty. Therefore, when a consultation is requested they make the diagnosis and complete the treatment with the consent of the referring physician.—HOWARD S. PFIRMAN, *administrator, Middlesex Hospital, Middletown, Conn.*

Purchasing Remains Impersonal

Judgment and taste are needed to avoid the dangers of gifts, donations and free samples from hospital suppliers and their salesmen

WHEN does a supplier's Christmas gift cease to be a wholesome token of friendship and appreciation and become a suggestive down payment on future favors, an obstruction to good business relations and good friendship as well?

Is there a happy medium between the embarrassingly stiff policy of the utilities company which requires its purchasing personnel to return all gifts from salesmen, on the one hand, and the evil practice of lavish entertainment and gifts for buyers, on the other?

Most hospital administrators believe there is such a safe middle ground, the Small Hospital Forum on purchasing practices in the postwar period reveals. Of 21 administrators replying to a question on this subject, less than half stated flatly that they did not under any circumstances accept personal gifts from salesmen or supplying firms at Christmas or other times.

The answer, in the opinion of those who believe that the practice is justified under certain circumstances, lies in good taste and good judgment on the part of both giver and receiver. Here are some of the statements that were made:

"Gifts have been nominal, usually trinkets that may be used at my desk or in the office—pencils, calendar holders and letter openers. Now and then there have been other things, like fruit cake or candy. I think that at Christmas there is no harm in accepting gifts of this kind if they are within reason and do not take on the complexion of a bribe for business. Not to accept gifts at this time would be misunderstood by salesmen. Now and then during the year salesmen have given pencils and other gadgets with their firms' names imprinted on them. I think this kind of gift is justifiable."

"I don't believe in becoming too friendly with salesmen," another opinion reads. "Friendship should never take the place of sound judgment. But I would not consider a box of candy or necktie at Christmas out of order."

"I find this practice embarrassing no matter how small the gift," said a third administrator. "It is impossible, however, to refuse to accept candy or a similar offering at Christmas from salesmen with whom we have been doing business over a long period of time. It is difficult to make an issue over a small remembrance at the holiday season, though I should much prefer no remembrance of any kind."

Many others expressed about the same opinions, mainly stressing two points: first, that gifts must be impersonal in nature and nominal in value to be acceptable and, second, that they must come from salesmen who are old friends of the hospital. It should be remembered, too, that there is a substantial minority opinion to the effect that no such gifts should be permissible.

How They Feel About Samples

About the same division of opinion prevailed on the question of free samples from suppliers. Of the 21 hospitals replying, seven said, "No samples!" Among those who disagreed with this stand were several who felt that samples led to more intelligent purchasing.

"Frequently a salesman is anxious for us to try a new product," one of these replies explained; "maybe a soap, or a new type of paint. When I am satisfied with the product I am already using, I tell the salesman that if he wishes to leave a sample, I will try his product. I think in

THANKS TO THESE CORRESPONDENTS

HOSPITAL	PERSON REPORTING
Bryan Memorial Hospital, Lincoln, Neb.	Rev. E. C. McDade
Grace Hospital, Banner Elk, N. C.	Roy A. Hannon
Brownsville General Hospital, Brownsville, Pa.	Mrs. L. S. Knuth
West Hudson Hospital, Kearny, N. J.	Margaret Hunter
Methodist State Hospital, Mitchell, S. D.	Mabel O. Woods, R.N.
Reynolds' Memorial Hospital, Glen Dale, W. Va.	L. Wade Hampton
Kennedy Deaconess Hospital, Havre, Mont.	Donna E. Watts
Jewish Hospital, Louisville, Ky.	E. D. Witham
St. Michael's Hospital, Grand Forks, N. D.	Sister Harriet
Welborn Memorial Baptist Hospital, Evansville, Ind.	John A. Stocking
Selma Baptist Hospital, Selma, Ala.	W. H. Slaughter
St. Catherine's Hospital, Garden City, Kan.	Sister M. Johanna
St. Francis Hospital, Breckenridge, Minn.	Sister Mary Thomasine, O.S.F.
Jackson Infirmary, Jackson, Miss.	Geo. E. Adkins, M.D.
All Saints Hospital, Fort Worth, Tex.	Eva M. Wallace
Bath Memorial Hospital, Bath, N. Y.	James Faucett
Porter Sanitarium and Hospital, Denver	J. C. Shull
Walworth County Hospital. Elkhorn, Wis.	Margaret Schloemer
Alexander Blain Hospital, Detroit	Mrs. Anne M. Catlin, R.N.
Boone County Hospital, Columbia, Mo.	Bertha E. Hochuli, R.N.
Provident Hospital and Free Dispensary, Baltimore	J. L. Procopé

such a case it is justifiable to ask for a sample."

"It is not necessary for hospitals to sample drugs," another stated, "since the doctors decide what drugs should be used. But cleaning supplies are sometimes left with us, as we discourage demonstrations and prefer to make our own tests." A few added that samples, especially of drugs, were useful for teaching purposes.

To the question, "Do you believe in soliciting donations to the hospital from the firms with which you deal?" the great majority of administrators replied, "Definitely not!" Only four hospitals saw any justification at all for donations from suppliers. One of these said that funds were accepted when offered, but never solicited.

Another solicits to a limited degree, since "all business firms provide a sum for donations in their budgets."

A third suggests that donations in the form of rebates on quantity purchases are harmless. The fourth hospital in this group neither solicits nor accepts donations but permits the Ladies' Aid to put the bite on suppliers for contributions to the annual spring benefit!

"High-Pressuring" a Nuisance

High-pressure salesmen are a major complaint of busy hospital superintendents, according to replies that listed purchasing problems and suggested possible solutions. "Overwhelmed with calls from salesmen," "Salesmen refuse to take 'No' for an answer but insist on going over their whole catalog," "Only problem is the high-pressure type of salesman," "Too many salesmen with new gadgets and materials trying to buck into new territory" are some of the specific comments that were offered on this subject.

Proposed improvements include closer supervision of salesmen, better scheduling and spacing of sales calls and, in the case of one outspoken superintendent who plainly feels strongly on this point: "Fewer salesmen." Another summed up what is apparently a widespread feeling when he said, "I want salesmen to take my 'No' quickly, and not to try to see me when I'm too busy."

One hospital pointed out that lack of standardization in many competitive lines made purchasing for the hospital unnecessarily complicated. "It would be helpful," he explained, "if many products were standardized as to specifications and type, including surgical supplies, janitors' supplies and general household supplies. Vendors could form an organization and standardize many of the commonly used hospital items. This would eliminate the large number of salesmen now needed."

Of course, the big purchasing problem is still shortages, though many report that the situation has improved in the past few months. On the whole, hospitals are deeply appreciative of the struggles their suppliers have gone through during the war. "We honestly feel the vendors did the very best they knew how. They cooperated with us at every turn" is typical of any number of comments that were made.

One way in which vendors can help out as long as shortages last is pointed out in an emphatic suggestion: Inform the hospital right away when ordered items are out of stock! Then the administrator can decide whether to place the order elsewhere or let it stand for later shipment, instead of waiting—sometimes for weeks or months—without knowing whether or when the supplies are going to arrive.

VOLUNTEER ACTIVITIES

Charlotte Looks Ahead

Mrs. A. Z. Travis, director of volunteers at Charlotte Memorial Hospital, Charlotte, N. C., reports the sending out of printed certificates expressing the hospital's appreciation of volunteer effort during the war. These are mailed out with letters stating the still present need and asking continued cooperation on the part of volunteer workers.

The Charlotte Community Council is planning a two day Volunteer Institute for February 4 and 5. Sponsored by all the social agencies in the city, its purpose is to acquaint the public with all the services offered by these agencies, to determine the way in which volunteers may be used in these organizations and, if public interest justifies it, to provide for the training and placing of volunteers as a community project.

Doll's House for Adults

A doll's house with an adult purpose is the one made by the woman's auxiliary sewing group for Evanston Hospital's child guidance clinic. Dr. Elizabeth MacDougall, head of the child guidance clinic at this well-known hospital in Evanston, Ill., outlined the requirements of the doll's house. It includes complete equipment pertinent to family living.

By observing the child at play with familiar objects, the child psychologist is helped to establish a diagnosis. The doll's house, of course, is only one project—an extra project at that—of the sewing group's program. Another extra is a money-maker for the institution, the making of articles for sale in the Auxiliary Shop. To get ideas of which objects are most saleable, a member of the sewing group works as an assistant in the shop each Monday.

Pennsylvania Dutch

Speaking of doll houses, No. 7 in the series made by Cedar branch of the Children's Hospital of the East Bay, Oakland, Calif., is a Pennsylvania Dutch farmhouse. Authentic in every particular, the four rooms and scullery make a fascinating home for the dolls, which are fashioned of wooden pegs.

The house itself is of Pennsylvania limestone and outside it stands an elm and hickory pump in the tradition of the period. Hand-hooked or braided rugs cover the floors. Dishes, painted under an enlarging glass, are copies of slip ware and spatter ware. The glass is Steigel and the figures of animals are copies of chalk ware. The cradle is a miniature of one in the Metropolitan Museum. The doll house was on display in a downtown hotel before its sale to swell the hospital's funds.

Booklet Serves as Guide

Suburban Hospital and Health Center, Bethesda, Md., has 400 volunteer workers. To acquaint them with the hospital and the duties of the various types of volunteer service, the women's auxiliary of the hospital last summer brought out a 20 page booklet. Filled with large illustrations and with the accompanying text at a minimum, the booklet both expresses the appreciation of the management of the hospital for volunteer service and acts as an inspiration and guide to the nonpaid workers.

One page of the booklet features the junior volunteer corps which is organized under the women's auxiliary.

Administrators

Col. Charles Rees Lloyd, director of Morristown Memorial Hospital, Morristown, N. J., for twenty-four years, is retiring, it has been announced. Simultaneously, announcement was made that his successor would be **Lt.-Col. Robert Giddings Boyd,** former superintendent of Presbyterian Hospital, San Juan, Puerto Rico, whose current assignment is with the Inter-American Defense Board in Washington. Colonel Boyd has been assured of his release by the War Department to accept the new post.

Colonel Lloyd, who has held the elective office of secretary of the board of trustees, as well as the position of director, is expected to continue to serve on the board.

Richard Highsmith, formerly administrative assistant at Evanston Hospital, Evanston, Ill., and more recently at Oak Ridge Hospital, Oak Ridge, Tenn., has accepted the post of administrator of Children's Hospital at Oakland, Calif. Mr. Highsmith succeeds **Keith Taylor,** who recently accepted the position of assistant administrator at Peralta Hospital, Oakland, Calif.

George Peck, managing officer of Illinois Eye and Ear Infirmary, Chicago, has been named administrator of Jewish Hospital, Philadelphia, filling the vacancy created by the resignation of **Jacob Goodfriend** in July.

Paul Fleming, first assistant director of the New Haven unit of Grace-New Haven Community Hospital, New Haven, Conn., became acting director upon the retirement of **James A. Hamilton** January 1. **Dudley Porter Miller** is now first assistant and **Charles V. Wynne** is third assistant. Mr. Fleming has served as assistant manager of Mills Memorial Hospital, San Mateo, Calif., and as administrator of Hahnemann Hospital, San Francisco.

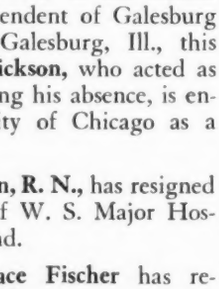
Mildred Riese has accepted the post of superintendent of Children's Hospital, Detroit. Since February 1944, she had served on the A.H.A. staff as nurse recruitment officer to coordinate the association's activities under contract with the U. S. Public Health Service for the cadet nurse corps program. Prior to joining the A.H.A. staff, Miss Riese was superintendent of Orthopaedic Hospital, Los Angeles, a position she held for twenty years.

Elmer E. Matthews, administrator of Wilkes-Barre General Hospital, Wilkes-Barre, Pa., since 1917, has resigned effective June 15. He is a founder and charter member of the Hospital Association of Pennsylvania, which he served as president in 1923 and 1924 and as treasurer since its inception. Mr. Matthews is a charter member and fellow of the American College of Hospital Administrators and a member of the American Hospital Association.

Leon A. Bondi, who has served with the United States Naval Reserve for the last three years, returns to his former position as superintendent of Galesburg Cottage Hospital, Galesburg, Ill., this month. **Eva H. Erickson,** who acted as superintendent during his absence, is entering the University of Chicago as a master's student.

Theresa Sweetman, R. N., has resigned as superintendent of W. S. Major Hospital, Shelbyville, Ind.

Sister M. Boniface Fischer has replaced **Sister M. Andrea** as superintendent of St. Vincent's Hospital, Crookston, Minn.



Arthur L. Bailey, formerly with the Keys-Houston Clinic Hospital, Murray, Ky., and the Union County Hospital, Morganfield, Ky., has been appointed administrator of the new Herbert J. Thomas Memorial Hospital, South Charleston, W. Va. Mr. Bailey is a charter member and former vice president of the West Kentucky Hospital Council and a member of the audit committee of the Kentucky Hospital Association. The institution, which was named in memory of the late Sgt. Herbert J. Thomas, U.S.M.C., who gave his life on Bougainville Island in the Solomons on November 7, 1943, and was posthumously awarded the Congressional Medal of Honor, was completed in December and is expected to be ready for occupancy in February.

T. T. Murray has been named superintendent of Hudson City Hospital, Hudson, N. Y., to fill the vacancy created by the recent resignation of **Julia L. Dougher.** Mr. Murray is a fellow of the American College of Hospital Administrators.

Dr. Mark A. Freedman has been selected as assistant director of Bronx Hospital, Bronx, N. Y. A graduate of Ohio State University College of Medicine, he served a one year internship at Montefiore Hospital, Pittsburgh, after which he was commissioned a first lieutenant in the Army in 1940. He served as executive officer in Army hospitals in the United States and in the Eastern Theater of Operations and was separated from service in the fall of 1945 with the rank of lieutenant colonel.

Ellison H. Capers, formerly personnel manager at the Hart Manufacturing Company, Poughkeepsie, N. Y., is the new administrator of Vassar Brothers Hospital, Poughkeepsie. He succeeds **Joseph J. Weber,** who is retiring after sixteen years of service. Mr. Weber, who has been active in local, state, and national hospital organizations, will remain at the hospital for several months to assist Mr. Capers.

A. J. Sullivan has assumed his duties as administrator of Memorial Hospital, formerly Epworth Hospital, South Bend, Ind. Prior to entering the Army, from which he was recently discharged, Mr. Sullivan was credit manager and administrative assistant at the University of Michigan Hospital, Ann Arbor, for eight years.

Mary Ferry has been appointed superintendent of Heaton Hospital, Montpelier, Vt., succeeding **Mrs. Mary R. Fader,** who held the position for the last three years. Miss Ferry has served as director of the school of nursing and superintendent of Wilmington General Hospital, Wilmington, Del., since 1937. She has been president of the Delaware State Nurses' Association for six years and a member of the Delaware Board of Nurse Examiners since 1933.

Sister Mary Alma has succeeded **Sister Mary Francis** as superintendent of St. Mary's Hospital, Scranton, Pa. Sister Mary Francis has been transferred to Mercy Hospital, Wilkes-Barre, Pa., as assistant director of nurses.

Sister M. Severine, superintendent of Sacred Heart Hospital, Allentown, Pa., has been named superior of St. Joseph's Health Resort at Wedron, Ill. **Sister M. Columbia** succeeds Sister Severine, who was head of Sacred Heart Hospital for

(*Continued on Page* 164.)

HEADLINE NEWS

Army Will Offer Refresher Training to Doctors Leaving Service

WASHINGTON, D. C.—Refresher training of twelve weeks' duration will be given Army doctors leaving the service who desire to brush up on latest developments in fields of medicine, surgery or neuropsychiatry, Maj. Gen. Norman T. Kirk, Surgeon General of the Army, announced December 31.

This training, which will prepare retiring Army doctors for return to private practice with latest knowledge of medical advances made during the war, will be given at Army hospitals until June 30.

Numerous requests have been received by the surgeon general from Reserve Corps, National Guard and AUS medical officers who are about to be separated and who desire to remain in service for a short period of professional duty prior to return to civilian life. These officers are anxious to return to their civilian practices with the advantages of the latest medical knowledge.

Owing to the tremendous demand for refresher training placed on civilian medical teaching centers, many of these medical officers have been unable to arrange for refresher training. The Army program will afford the medical officer a period of clinical work under supervision and excellent opportunities for collateral study of recent advances that have been made in medicine, surgery and neuropsychiatry.

Pay Inequalities of Navy Nurses Will Be Corrected

A Bill (H.R. 4411; S. 1491), correcting inequalities in disability retirement pay of Navy nurses in comparison with that received by Army nurses and by all male and female officers of the armed forces, has been signed by President Truman. Navy nurse ensigns, disabled in line of duty, will retire now at a monthly pay of $112.50 instead of $67.50; all other retiring Nurse Corps officers will benefit also in accordance with the pay of their rank.

Because of legal technicalities, disabled nurses were retired previously with a pay of 75 per cent of active duty pay at the time of retirement, based on the permanent pay bill of June 1942, rather than on the higher pay bill legislated in December 1942.

Pecora Enjoins Hospital Strikers; Stresses Urgency of Health Service

In a 7500 word decision reviewing the relationship of hospitals to community welfare and stressing the urgency of hospital work, Justice Ferdinand Pecora of the New York State Supreme Court declared that hospital employes have neither the legal nor the moral right to go on strikes. Justice Pecora granted a permanent injunction to the New York Hospital restraining striking members of the New York Building and Construction Trades Council's Maintenance Organization, an A. F. of L. affiliate.

Holding that hospitals cannot function properly if they are subject to interference with their activities by strikes, Justice Pecora nevertheless maintained that hospital employes must be permitted to picket. This right, it is pointed out in the decision, is consistent with an American's constitutional guaranties as defined in a labor case by the United States Supreme Court.

Patients Must Be Served

Underlining the "immediacy" of surgical and other emergency hospital cases, Justice Pecora stated that the needs of such patients cannot be suspended "awaiting the outcome of parleys between the hospital management and its employes over terms of labor." Pointing to the direct connection between the welfare of patients and plant maintenance operations in many departments, the court ruled that the generally broad right to strike must be limited by the life and death necessity of uninterrupted hospital service.

Elevator operators, electricians, carpenters and power plant workers were involved in the New York Hospital strike, which lasted a month. Estimates of the number of strikers varied from the union's claim that 164 workers had walked out to the hospital's contention that only 116 had left their jobs and many of these returned before the strike ended. During the strike, volunteers manned the elevators and maintenance supervisory employes worked double shifts to keep the plant running.

According to a statement issued by Murray Sargent, hospital director, the strike was called by the union for organizing purposes, since there was no dispute about wages or working conditions. Harold Stern, attorney for the union, said that the Pecora ruling would be appealed, if necessary, all the way to the U. S. Supreme Court.

New C.P.A. Order Places Penicillin Under Allocation

WASHINGTON, D. C.—An upsurge in the demand for penicillin necessitated placing all types of penicillin under allocation, the Civilian Production Administration announced January 1. Simultaneously with the issuance of the new allocation order, C.P.A. revoked the order requiring producers to treat civilian hospital orders as preferred orders to the extent of 40 per cent of monthly production.

Allocation of penicillin will be made at the producers' level. Consumers will not file applications with C.P.A. but will procure the drug from their suppliers in the usual manner.

Through the allocation action C.P.A. expects to ensure the fulfillment of increased requirements for the Army, Navy, Veterans Administration and the United States Public Health Service, as well as to channel additional supplies to domestic consumers. The new allocation order will make more penicillin available for parenteral use by civilian hospitals, doctors and pharmacies in January than in any previous month.

Although production of penicillin has been steadily increasing, the demand for the war-born drug has been so great that even greatly expanded production has been unable to keep pace with it.

House Gets Bill to Aid Hospitals

WASHINGTON, D. C.—A bill to authorize loans and grants to hospitals and public health centers for planning, constructing and improving their facilities was introduced in the House of Representatives by Lyndon B. Johnson December 17. The Reconstruction Finance Corporation would administer the act which authorizes a sum not exceeding a total of $500,000,000 for the planning, construction, improvement and extension of hospitals and public health centers.

Grants toward the cost of planning, constructing, improving or enlarging any hospital or public health center would be made in an amount not exceeding 40 per cent of the cost. Loans would be made for a term not to exceed forty years at interest not to exceed 2 per cent per year.

Statewide Contract for Veterans Is Effected by Michigan Doctors

"Home town care of veterans" for service-connected disabilities, with free choice of doctors, will be offered as a standard practice for the first time through an agreement between Michigan Medical Service and the Veterans Administration signed in Washington December 27.

A similar agreement with Michigan Hospital Service which would entitle veterans with service-connected disabilities to local hospital care also is under consideration, according to W. H. Lichty, director of Michigan Hospital Service.

The agreements may provide a pattern for local care of veterans throughout the nation, and spokesmen for the Veterans Administration already have expressed the hope that some such program can be developed speedily on a national basis.

Doctors providing service to veterans will be reimbursed through Michigan Medical Service, the doctor-sponsored plan which is the companion organization to Michigan Hospital Service. Fees will be paid according to a schedule developed after prolonged study by the Michigan State Medical Society and approved by the Veterans Administration. Michigan Medical Service will be repaid by the Veterans Administration.

Under the contemplated program for local hospital care, hospitals would be paid by Michigan Hospital Service on the basis of the cost of providing the service, and Michigan Hospital Service would be reimbursed by the Veterans Administration.

Full support for the proposed hospital care program has been voted by both the trustees of the Michigan Hospital Association and the Greater Detroit Hospital Council, according to the Rev. Dr. John L. Ernst, association president.

In practice, the veterans care program will work much like that by which the Michigan service plans now provide hospital and medical services to more than 1,250,000 residents of Michigan. For treatment or care necessitated by service-connected disability, the veteran will go to any doctor or hospital participating in the program. If he has previous authorization, as is expected for the great majority of cases, the hospital or doctor will send the bill to Michigan Hospital Service or Michigan Medical Service. The service plans then will make payment and will be reimbursed by the Veterans Administration.

Special arrangements will be made for emergency cases. While details still must be worked out, it is expected that the great majority of emergency cases will be handled in such a way that the hospital or doctor involved can be notified immediately by the service plans that the case is or is not a Veterans Administration liability.

To facilitate prompt handling of all cases, the Veterans Administration will open offices near the Blue Cross headquarters in Detroit.

Veterans of the women's services are expected to be entitled to care for both service-connected and non-service-connected disabilities, since they cannot be accommodated at present in all veterans' hospitals.

More Doctors, Nurses Eligible for Release From Army and Navy

By EVA ADAMS CROSS

WASHINGTON, D. C.—The War Department announced December 15 that a group of 15,000 physicians had just been made eligible for discharge through a lowering of the critical score from 80 to 70. The time factor also has been cut. The Navy expected to have 5500 doctors ready for release by the end of December. The Army's new critical score of 70 is designed to get doctors back to their home communities as speedily as possible.

Since VE-Day, more than 15,000 physicians have been released from the Army and more than 4000 from the Navy. With the additional Army group of 15,000 made eligible for release by the recent announcement, two thirds of the physicians in the Army as of VE-Day are practically on their way back to civilian practice.

The new critical score of 70 applies to all Medical Corps officers except for those in certain categories. For plastic surgeons, eye, ear and nose specialists, orthopedic surgeons and internal medicine specialists, the discharge requirement continues to be 80 points or continuous service since Pearl Harbor. A requirement of 70 points, or forty-five months' service, has been established for gastro-enterologists, cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists and pathologists.

The liberalized standards apply also to nurses and other Medical Department personnel. The point score for nurses has been cut from 35 to 25 and the discharge age, from 35 to 30. Nurses will also be eligible for discharge after two years of service. Those on duty in the United States who are classed as limited service have been added to the list of those qualified for discharge.

It is estimated that this will make 12,500 nurses eligible for release, in addition to the 27,000 who have already been qualified to return to civilian life. Some 22,000 nurses have been discharged as of December 15. The peak strength of the Army Nurse Corps was 57,000.

For officers of the Medical Administrative Corps, the score has been dropped from 70 to 60, the pre-Pearl Harbor service requirement has been eliminated and the time of service required for discharge has been cut to forty-two months. Four thousand officers are thus made eligible for discharge under the new standards.

For physical therapists, the score has been reduced from 40 to 25 and the age requirement, from 40 to 30. Two years of service will also qualify a physical therapist for discharge. Five hundred women officers are affected.

Three hundred additional dietitians have been made eligible to leave the Army by a cut in their score from 40 points to 30 and in their age requirement, from 40 to 35.

Senate Approves S. 191, Federal Aid Bill for Hospital Construction

By EVA ADAMS CROSS

WASHINGTON, D. C.—S.191, the federal aid bill for construction of hospitals and health centers, has been approved by the Senate. The bill proposes a program of federal grants-in-aid for assisting the states to ascertain their hospital and public health facility needs and to develop statewide programs for construction of those facilities needed, and to aid in the construction of necessary facilities for public and voluntary nonprofit hospitals and for public health centers.

An appropriation of $5,000,000 is authorized for the survey and planning features of the bill, and $75,000,000 for each of the five fiscal years 1947 to 1951 for the construction program. The federal administration would be entrusted to the surgeon general of the U. S. Public Health Service who would be given the assistance of a Federal Hospital Council.

Senators Wagner and Murray vainly attempted to make several amendments to the bill which would bring it more in line with President Truman's recent request for a national health program.

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Careful Selection Stops "Staff Troubles"

FREDERICK T. HILL, M.D.

Thayer Hospital
Waterville, Me.

IT IS generally assumed that the trustees will be responsible for the business policies of the hospital and, with that end in view, will exercise their best judgment in the selection of the administrative staff.

What is not so generally understood is that the trustees are quite as responsible for the standard of medical service in the institution. Representing the people of the community, the potential patients of the hospital, they cannot absolve themselves of this responsibility. Therefore, they must be concerned with the selection of the medical staff, for thereon depend the quality of professional service and, to a great extent, the efficiency with which the hospital will function.

With rare exceptions the physicians making up the staffs of our hospitals are intelligent, conscientious persons who have chosen medicine as a career because of a sincere desire to practice the healing art.

Responsibility for Patient

Too often, the physician tends to think of the hospital merely as his own workshop and his patients as his private medical property. This reflects the attitude of earlier days when the hospital was simply a place in which to treat his patients and was dependent upon his good will for the revenue necessary for operation. There is no place for this sort of thing in the modern hospital. Today we must accept the philosophy that the hospital has the responsibility for the safety and well-being of its patients and, thus, must see to it that the highest possible standard of professional service is available. This must be done through a staff that is in turn responsible to the hospital and that combines the best professional skill and ability. Any institution that is in the business merely of renting rooms and furnishing board, with nursing care thrown in for a consideration, is little more than a medical boarding house.

"Staff trouble" is one of the commonest complaints of hospitals. This is a sort of secret disease which one endeavors to keep from public notice but which tends to break out sporadically in many institutions. It usually has an insidious onset and its prodromal symptoms may be difficult to recognize. But once it reaches its peak it has a malign and destructive effect upon the entire hospital. It is a frequent cause of excruciating headache to the trustees and the administrator and, at times, may be fatal to the latter—economically.

It is interesting to note that this malady occurs most frequently in the smaller community hospital and is rarely encountered in the larger institutions, particularly those with medical school or university connections. At first glance this relative immunity might be attributed to a better and more amenable type of staff physician. But this generalization is hardly fair, for one will find quite as high-grade conscientious doctors in the community hospital.

Undoubtedly, there are better discipline and organization and more incentive for cooperative effort in the larger hospital. Staff appointment is not easily attained. Men are selected for what they may ultimately contribute to the hospital, and with the expectation that later they will fill teaching positions. Promotion usually is on the merit basis. Tradition and academic background do a great deal to minimize politics and personalities.

There is pride in such hospital affiliation and members are inoculated early with the aims and ideals of the institution. Perhaps this may be the greatest reason for its comparative freedom from staff troubles. If this is so, the trustees of hospitals subject to this unhappy condition might well emulate the more nearly immune institutions in many matters of staff policies.

While, on the whole, the standard of medical service in this country has been on a high level, this has not been universal, even in any one community. If we are honest with ourselves, we must admit that there may be considerable variation in the quality of service within many a hospital. This should not be ignored, but earnest efforts should be made to correct it by bringing the entire service up to as high a level as possible. The only solution is to select the best possible staff and then strive for still further improvement. This is a definite responsibility of the trustees.

Who Should Make Appointments?

While there may be some difference of opinion as to the modus operandi in the selection of a staff, it is generally conceded that appointments should be made by the trustees. The American Medical Association recommends such appointments "upon nomination by the staff." This may not always be the best procedure as it makes such appointments originate in the staff.

There have been occasions when older physicians, through personal motives, have kept desirable men from the staff. There have been hospitals in which an "inbred" staff habitually kept out all younger men, no matter how well qualified, so that when, along with graying hairs and advancing years, appointment eventually was attained, it carried with it a certain cynicism and spirit of "keeping out the other fellow," which is not in the best interests of the hospital.

Certain staffs may nominate any physician licensed to practice, regardless of his qualifications. It is not to be expected that a lay board alone would possess the necessary ability to pass on the professional qualifications of prospective staff members but it should exert something more than a blanket endorsement of such candidates. Local conditions must determine the best pro-

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BARELY a year ago the reports regarding the use of penicillin in subacute bacterial endocarditis were hardly optimistic. Outstanding clinicians doubted if more than temporary sterilization of the blood stream could be expected. When the wider availability of penicillin permitted more intensive and prolonged therapy, endocarditis in many instances yielded. As recent publications show,* this serious infection, heretofore practically hopeless, no longer need be considered so.

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cedure to be followed but, in the final analysis, the trustees are responsible and should take this responsibility seriously.

Qualification for staff membership should not depend upon personal friendship, family ties, social prominence, church affiliations or the prospect for remunerative patients. It should rest solely upon professional ability. This is a broad term and encompasses, besides adequate training and skill, integrity, industry, idealism and a medical conscience. All this may be difficult to evaluate but careful investigation, often no more than the banker trustee would exercise regarding a potential loan, will furnish a great deal of information. Medical education, residencies, professional society affiliations and certification by national examining boards are helpful determining factors.

Appointments should be made on an annual basis. This hardly permits argument and may prevent trouble in handling possibly discordant elements at some later date.

Medical Director an Asset

The idea of a medical director, even for a small hospital, has merit. This does not refer to the superintendent who possesses the degree of M.D. but who devotes his time entirely to administrative matters. It means a physician, a clinician, appointed by the trustees to represent them and to have supervision of the medical work in the hospital. It should not be difficult to select some physician of undisputed standing and leadership in whom both the trustees and staff have confidence. It need not necessarily entail any added financial burden for the director could work on a voluntary basis. The satisfaction of improved staff activities should be sufficient recompense. Such a person can be of inestimable value in advising the trustees on staff appointments.

If the hospital is divided into services, naturally the several chiefs of service may likewise act in an advisory capacity to the trustees. Hospitals and physicians being as they are, a benign dictatorship functions more efficiently than does an attempt at democracy with its inevitable fluctuations, as is often seen when the staff annually elects its presidents. The person selected may be quite satisfactory presiding at a staff meeting but often fails miserably in the larger matters of staff relations.

Obviously, much of this discussion is not pertinent to the hospital with an "open" staff. And if staff appointments are properly managed there should be little argument for the open staff. Certainly, if it is to function efficiently and in the interests of its patients, the hospital must select its physicians. But the closed staff should be closed only to those physicians who are not qualified or who do not subscribe to the established standards. A better term is "selected staff."

The courtesy staff, if properly utilized, can be of great advantage. Younger men, who meet the qualifications but who have not yet had time to prove themselves, may well be given such appointments, working on probation, as it were, and under the supervision of the older men. But it should be understood that this supervision pertains to the private patient just as much as it does to the service case in the ward. There should be none of the medical boarding house atmosphere. And when the younger man has demonstrated his professional ability he should be in line for advancement to the active staff.

At times it may be desirable to extend the privileges of the hospital to a member of another hospital staff for some particular case. It should be the responsibility of the medical director to assure himself of the physician's qualifications and, if necessary, to guide him along lines in keeping with the standards of the hospital.

In addition to selecting a good staff, it is important to maintain the staff on as high a level as possible. With this objective in mind a program of continuation education becomes necessary. Medicine is not an exact science and new developments and discoveries bring constant changes. Every hospital worthy of the name should be a teaching hospital. There is ample material even in the community hospital if it is only used. Monthly staff meetings, or better still, weekly ones, should be educational. This is of great aid in developing a good staff into a better one.

It may not always be easy for trustees to evaluate the standard of medical care in the hospital. Again, the medical director can be of great assistance. But considerable personal appraisal can and should be done by the trustees. It should not be difficult to ascertain whether or not a good teaching program is carried on and what members actively participate in it.

Most boards have members who are active business men. They are in the habit of depending upon audits to know the state of their business. The same information regarding the state of staff activities can be gained by the routine use of the staff audit.

Patients Must Be Protected

Some of these things may seem difficult to accomplish, especially in a community with only one hospital. Sentiment may be against excluding any physician from the staff, no matter how unqualified he may be. Occasionally, discordant elements in the staff can be handled only by refusing them the privileges of the hospital and this may meet with opposition. But risking this would be preferable to compromising the safety and well-being of patients to incompetent or neglectful professional care.

Sometimes, indeed, it may seem difficult to maintain good records, to have worth-while staff meetings or to prevent mental stagnation among some of the members. But trustees should not exhibit a defeatist attitude. There is a moral obligation in their trusteeship to see that these things are done. Here is where a board of trustees should exhibit both courage and steadfastness of purpose when the occasion justifies.

These occasions will be rare, however. For the most part the medical staff realizes the importance of progressive cooperative measures. The same rugged individualism, which is sometimes so threatening, can usually be merged into a group consciousness which makes for a real esprit de corps.

Question of the Month

Space limitations preclude the publication of the Question of the Month in its customary space on this page. It will be found on Page 63.

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The Treatment of Diabetics

ELLIOTT P. JOSLIN, M.D.
Medical Director
George F. Baker Clinic
New England Deaconess Hospital
Boston

RECENTLY I was forced to do something that I have never been obliged to do in all my years of practice. A diabetic patient needing hospitalization arrived at my house during the evening. It proved impossible to find him a hospital bed, a bed in a nursing home or a room in any of the near-by hotels. Although both Mrs. Joslin and I are somewhat mature and two children and two grandchildren were unexpectedly staying with us we took him in for the night. This brought home quite forcibly the actual shortage of hospital beds about which we have been reading. With this situation in mind and the acknowledged increasing number of diabetics confronting us, it is evident that new arrangements must be made for their treatment.

Complications Are Increased

The percentage of the total number of diabetics requiring bed care, it is true, is less than ever, but the total number has grown so much as to offset this reduction. Diabetics now are living three or four times as long as formerly; they are acquiring late complications of the disease in the heart, legs, kidneys and eyes and, in addition, are beset with such other diseases as goiter, gall stones and cancer which for their remedy require expert diabetic supervision.

In other words, the demand for beds for diabetics is so great that space in the hospital must be reserved for those patients who need actual bed-nursing care. Also, a few more beds must be set aside for admissions of diabetic coma cases and those with insulin reactions or, equally important, for those who are suspected of having these conditions but who may have some complication as serious or worse of which a precise diagnosis has not been made because the family doctor has not the laboratory facilities or the time to attempt it. Hospital administrators, therefore, should plan in any new construction to meet these diabetic situations, which are bound to increase.

A second type of diabetics presenting themselves for treatment are the hitherto ambulatory hospital patients who want a week's introduction into the management of this disease, who have been puzzled at home with its control, who have complaints requiring diagnostic studies or who come back after months or years to be brought up to date in diabetic knowledge, partly because of their scientific interest. Years ago we supervised such individuals in a little frame house and when pressed for hospital beds began again to do so in 1944. In the following months, about one fifth, and more recently one third, of the number of diabetics usually treated in the New England Deaconess Hospital were thus cared for.

These patients have been ministered to by a trained housekeeping nurse, an eight hour teaching diabetic nurse and a part-time technician. Detailed laboratory procedures are carried out at our office or at the hospital across the street. Often we swap patients with the hospital, we on our part taking an ambulatory patient so that the hospital can free a bed for an emergency, or the hospital taking such a patient for us.

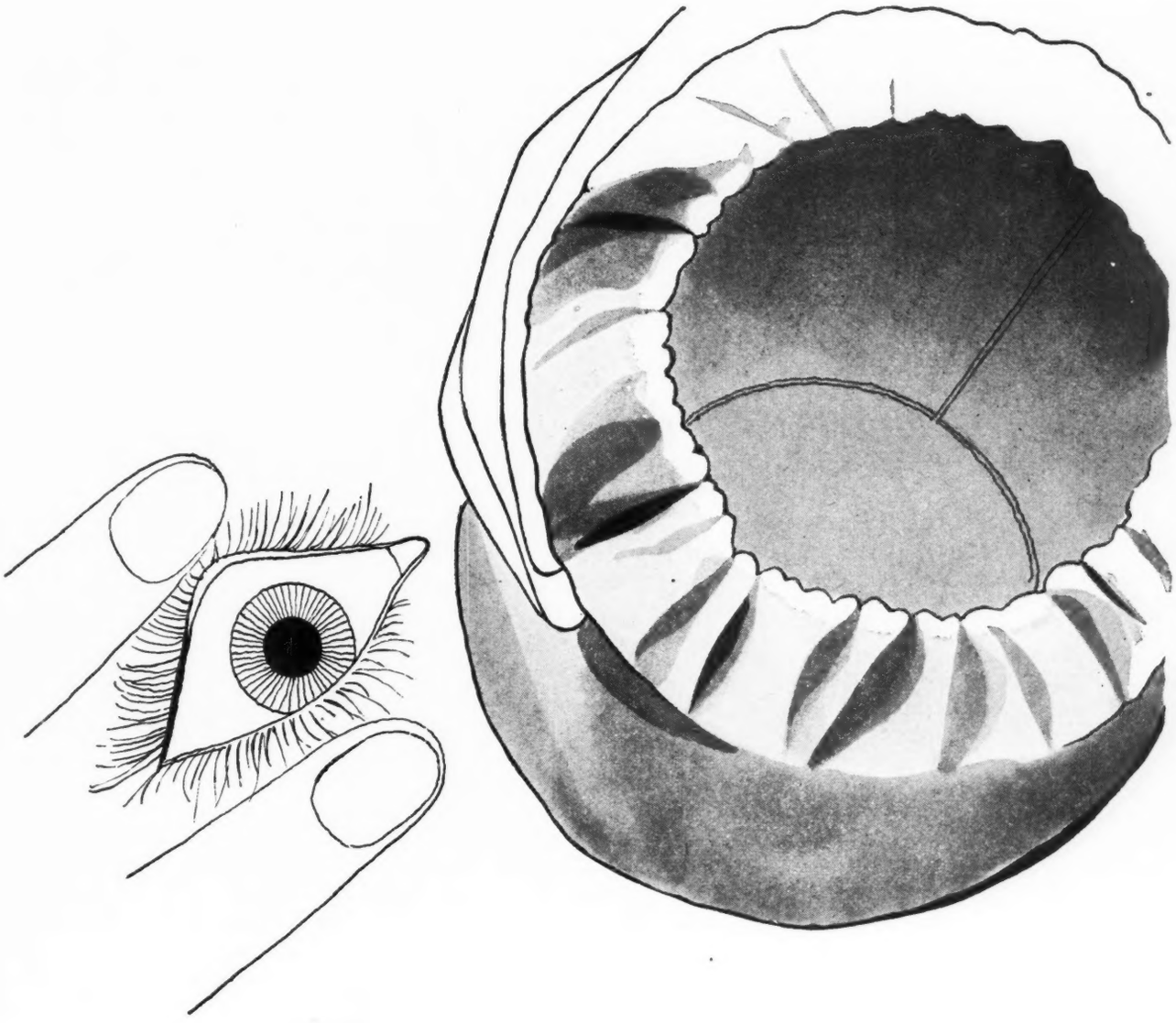
A week's stay is generally allowed for this nursing home group. It is essential for both patients and doctors to concentrate on treatment and education. Patients if they are not bedridden can come to the two daily classes at the hospital just as the hospital patients come; in addition, these patients have specialized instruction from the diabetic-teaching nurse and especially from one another because each one is supposed to help his neighbor. It is a good plan for the patient to realize that it is up to him to take advantage of the privilege of detailed diabetic instruction and that someone is waiting to get his bed at the end of his week. I do not claim there is anything new about this method of handling diabetics. I simply want to emphasize its importance.

Another lesson for hospital superintendents is to be learned from this group of patients treated in a frame house, namely, that such ambulatory patients require little attention and could be assembled from all over the hospital and kept on one floor. One third or not more than one half the nursing staff would be necessary and nurse's aides, undergraduates or attendants could look out for the patients and thus obviate the closure of an entire floor for lack of nurses. It does not require a super-trained nurse to watch over a goiter patient waiting for operation or in late convalescence, over an appendix patient who the surgeons think so far recovered that she is allowed to get out of bed and start walking around in three days or over a diabetic patient with an amputation of a foot or leg whose dressing may not be changed for a week and who is not in need of a daily visit by the surgeon.

Family Doctor Cares for Most

The third class of diabetics to be treated is the largest of all, namely, those who are being cared for by the family doctor. At present, the physician does not have a fair show in caring for his patients. For his own peace of mind and self-protection he should be furnished facilities for laboratory work at cheap rates; otherwise he is handicapped at the very start. The only chance he, or in fact any of us practicing doctors, has to survive the pressure of treating more and more patients with less and less money in return is to treat them more *en masse* and that means he must have someone to help him.

I acknowledge that the greatest sermon in the world had an audience



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of one and each patient should have an individual sermon, but sometimes far more is learned by each one of a group of patients when the doctor is keyed up to do his best and talks to the group at once, than if he spent less time on each individual member of the class.

What is the overworked practitioner to do? I think his secretary, his nurse, his technician, his wife or his child should be offered a week's course in diabetic history taking, urine testing, diet measuring, insulin administering and so set his hours free. We at the George F. Baker Clinic of the New England Deaconess Hospital would welcome the opportunity of experimenting with this type of diabetic instruction just as we have intermittently in the past and now are happy to have nurses come for two weeks or more to learn about the care of diabetics.

Bed Rest in Tuberculosis

ALBERT MARTIN, M.D.

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A REVIEW of medical literature from ancient times to the present in regard to the use and abuse of bed rest in disease supports the contention that there actually exists today a gross abuse of bed rest in the treatment of certain cases of tuberculosis.

The principal toxic symptoms of pulmonary, or extrapulmonary, tuberculosis are: cough, expectoration, fever, increased pulse and respiratory rate, loss of weight and appetite, chest pains, muscle soreness, fatigue, general malaise, shortness of breath, pulmonary hemorrhage, sore throat, painful swallowing, partial or total loss of voice, apprehensiveness, anemia and general debility. In subacute cases any or nearly all of these manifestations may become lessened or entirely absent, according to the degree of body resistance of the individual and the virulence of the invading tubercle bacillus.

Start Rehabilitation Early

Regardless of the classification of tuberculosis, whether minimal, moderately advanced or far advanced, if the patient has successfully passed from the acute and subacute states into the nontoxic clinical state, at which time he is virtually free from the toxic symptoms enumerated, he should be embarked on a graduated course of recreational, educational, vocational and physical rehabilitation.

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Experienced clinicians are convinced that many bacilli-free, nontoxic, symptom-free patients with pulmonary tuberculosis who are destined to undergo from eighteen to twenty-two hours of bed rest daily for months or years simply because of the x-ray findings could well be discharged as having received maximum hospital benefit. Such patients, it is felt, should be encouraged and aided to become either partially or entirely self-supporting. They would be, of course, under medical supervision with periodical x-ray and physical examination rechecks as safeguards to themselves, their immediate contacts and the public health.

Although no definite limitation of hospitalization, with prescribed bed rest, can be placed on patients who continue to present toxic manifestations and have indisputable x-ray and physical findings, it is unnecessary to insist upon a regimen of strict bed rest for the nontoxic patient who no longer feels ill, even though the x-ray film does not as yet show a completely fibrosed or healed lesion in one or both lungs.

The chest x-ray films are so frequently misleading or so often are found to remain "unchanged" over months or even years, while the patient's clinical status remains good, that no time should be lost in establishing graduated occupational, vocational and exercise therapy.

Body resistance in tuberculosis has been defined as "the individual's ability to accomplish worth-while things without any serious detriment to his physical, mental or spiritual well-being." It was proved long ago that the body resistance of the tuberculous individual under competent medical guidance is capable of producing many so-called miracles of recovery.

Today, with all our new aids to treatment and diagnosis, we still hold that strong body resistance in tuberculous persons may produce as complete and uneventful recoveries as occurred in the early days of tuberculosis treatment.

Individual Care Desirable

Selection and individualization in each case seem to be the order of the day. Each case is appraised and judged and the best method of treatment is then usually decided upon after a thorough physical and mental evaluation of the patient.

In *Coronet* for March 1945, Dr. Herbert L. Herschensohn points out the following deleterious effects that prolonged rest in bed may cause:

1. Gastrointestinal disturbances and, often, the beginning of a lifetime addition to cathartics.
2. Kidney and bladder disturbances of all kinds.
3. Muscle aches and atrophies.
4. Hypostatic pneumonia and pulmonary embolism.
5. Bedsores.
6. Extreme weakness.
7. Psychic disturbances.

After close to thirty years of diligent study, treatment and observation of tuberculous patients, my honest opinion is that patients with x-ray findings that are not sufficiently supported by definite clinical signs or symptoms of a toxic state should not be subjected to strict, prolonged periods of bed rest.

Upon reaching the nontoxic stage, they should be immediately started on minor physical and mental activities, these to be increased gradually under competent medical supervision and observation leading to a well-planned program of educational, vocational and physical exercise courses for final rehabilitation.

A great many persons who have had pneumothorax and other types of surgical collapse are now earning a livelihood in properly selected occupations, the "pneumo" patients receiving their air refills periodically while so employed. There are likewise many tuberculous patients in all classes and professions who occasionally have positive sputum or serum but who otherwise possess such strong body resistance that they can carry on successfully, without physical detriment, in the happy business of getting well. Many become free from the tubercle bacilli in doing so.

They Live Longer This Way

Being nontoxic, well nourished and fully resistant to their daily program, these persons are happier and live longer than they possibly could under a strict regimen of bed rest. Bacilli carriers of this class are usually well educated and well trained in preventive measures and do not spread their disease to others.

The careless, untrained or ill-advised bacilli carriers, as well as those not amenable to reason, should be legally required to submit to segregation for proper medical treatment and training on matters of disease prevention for the benefit of the public health and their own future well-being.

In practically all admissions to hospitals and sanatoriums of nontoxic, bacilli-free patients, from thirty to ninety days of bed rest should be more than sufficient to remove any vestige of weakness or fatigue and should also allow sufficient time for thorough laboratory study with one or more x-ray and physical examination rechecks.

The G. I. and Hospital Pharmacy

HENRY M. BURLAGE
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IN THE November issue of The MODERN HOSPITAL a number of proposed programs in hospital pharmacy for discharged veterans were discussed. Since that time the staff of the school of pharmacy of the University of North Carolina and the secretary of the North Carolina State Board of Pharmacy have given considerable attention to the development of a suitable program in this branch of pharmacy for this group of individuals.

Before the time to be allotted for such a program was decided upon, an outline of didactic instruction and laboratory work was drawn up and submitted to the executive committee of the American Society of Hospital Pharmacists for its examination and suggestions. At the same time, this committee was asked for an opinion regarding the proper time necessary to give a suitable program to these students and it was unanimous in stating that such a program should be at least one year in duration for the best interests of hospital pharmacy.

As the school of pharmacy of the University of North Carolina has no direct connection with a university hospital, it seemed advisable to establish affiliations with one or more hospitals in the state which operate hospital pharmacies under the supervision of a registered pharmacist and in which the applicant might serve a suitable internship. Such affiliations have now been established with at least four hospitals.

Under the program, as now established under the so-called "war college" of the university, the applicant will be expected to attend forty-eight hours of lectures at the school of pharmacy at a suitable time, preferably at the beginning of the program, and to spend a minimum of 1920 hours in laboratory work in the affiliated hospital of the applicant's choice. The applicant must be a registered pharmacist or a graduate with a bachelor of science degree in pharmacy.

Credit in the laboratory work may be given for experience obtained in hospital pharmacy while serving in the armed forces up to an amount not to exceed one half of the 1920 hours. Since this laboratory work is conducted under the supervision of a registered pharmacist, it is expected that this experience might be counted toward that required for registration as a pharmacist.

Certain materials and facilities are to be furnished by the affiliated hospital but these do not include housing or any compensation for services. A nominal fee will be charged for the didactic instruction and this is to be paid to the university by the Veterans Administration.

Acquaints Student With Hospital

The laboratory work, which constitutes the major portion of the clock-hour requirements of the program, is intended to acquaint the person with the organization and management of a hospital and the pharmacy with its 20 or more essential and important activities, including sterilization, parenteral solutions, bacteriological stains and reagents. The didactic instruction deals with an elaborate development of the phases of laboratory work, materials and appliances of concern to the pharmacy, the use of the library and the preparation of one or more papers dealing with special topics on hospital pharmacy.

Upon the conclusion of the program in a creditable manner, the candidate will be presented with a certificate by the university and by the affiliated hospital in which the laboratory work was conducted.

Determining Proper Dosage

EDWIN P. HIATT
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WHEN one administers a drug it is desirable to attain an effective concentration at the site of action for as long as is necessary to get the desired effect. At the same time one wishes to avoid concentrations that are harmful to the subject.

It is axiomatic that almost any therapeutically active drug is toxic to the subject if the concentration is too high. Because of the great variation in the way different drugs are treated in the body, the manner of administration of a drug is of the greatest importance.

The plasma concentration of an agent introduced into the body fluids is usually taken as a reflection of the concentration at the site of action. This is not always true, for reasons to be mentioned, but it is usually the case and it is certain that there is at present no better index.

It is my purpose to discuss some of the factors influencing the plasma concentration of certain antibacterial and antiplasmodial drugs in common use (sulfonamides, penicillin and quinine) in order to illustrate the general principles involved.

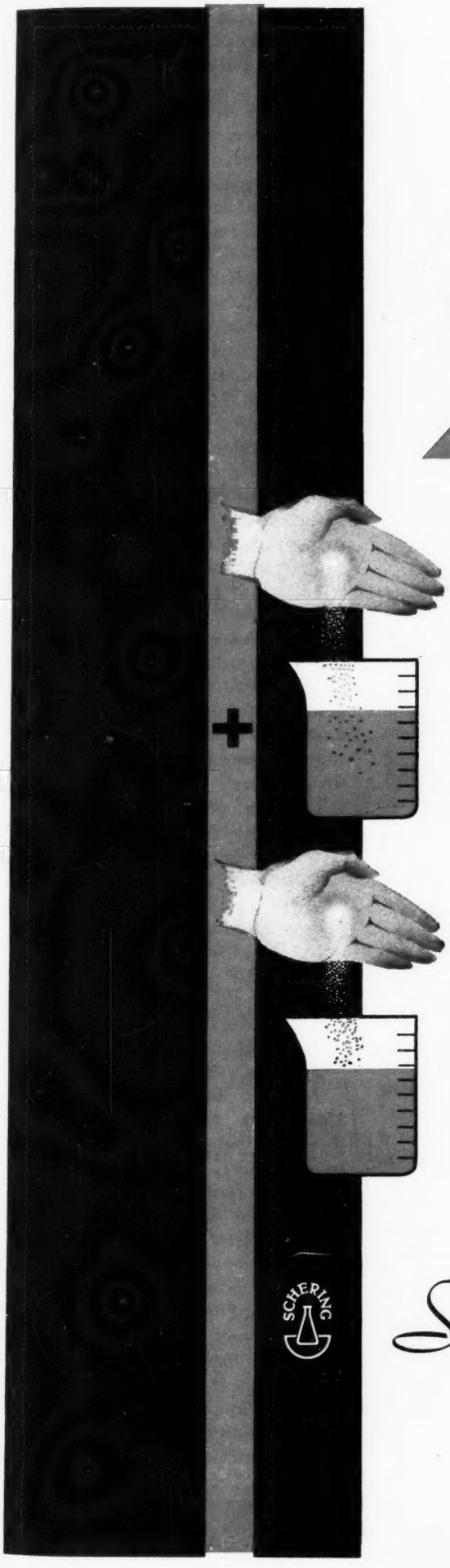
Factors Influencing Plasma Concentration. The factors which together determine the plasma concentration of any drug are: (1) the quantity administered, (2) the rate of administration or absorption, (3) the manner of distribution in body fluids, (4) the rate of metabolic destruction or alteration and (5) the rate of excretion.

I shall be chiefly concerned in this article with the last three factors, which lie in the no-man's land between physiology, pharmacology and biochemistry and consequently are occasionally neglected in the training of those who will use the drugs. I hope that this occasional neglect may be sufficient justification for a brief outline of the subject.

Distribution in Body Fluids. There are two main variables to be considered under this heading. First, is the agent limited to extracellular fluids or does it penetrate into the fluids within the cells? Second, is the drug adsorbed or bound to plasma or tissue proteins and if so, to what degree?

Considering the volume of distribution, we can start by saying that no therapeutic drug, to our knowledge, is restricted to the blood, even after intravenous administration. For a substance to be so restricted it must be completely bound to plasma proteins or to blood cells or it must be of a particle size large enough to prevent its filtration through the capillary endothelium.

Plasma Protein Adsorption. Before discussing the distribution of these agents through the body fluids, it will be well first to consider what percentage of the plasma concentration is adsorbed or bound to plasma proteins, since this fraction is not



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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11, 1945.
2. Lehr, D.: In press.

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available for free diffusion through the capillary membranes and will consequently limit the rate of excretion and the concentration in extravascular fluid compartments. It is found that with some of these agents the protein-bound fraction is the greater part of the plasma concentration.

A somewhat smaller fraction of the cinchona alkaloids is adsorbed on proteins while the different sulfonamide drugs vary over a wide range in this regard. (Approximate values: sulfathiazole, 60 per cent; sulfamerazine, 40 to 60 per cent; sulfapyridine, 30 per cent; sulfadiazine, 20 per cent; sulfanilamide, 10 per cent.) We have been unable to find any observations on protein binding of penicillin or streptomycin.

Entrance Into Red Cells. The red cells are not typical of tissue cells in general in their permeability so that one cannot assume that because a substance enters red cells it also enters tissue cells. However, if a substance does not enter red cells, it usually does not enter other cells.

Penetration into red cells is important in the case of drugs which cause an alteration of hemoglobin, as do some of the sulfonamides. It is also of importance in the case of antimalarial drugs which must enter the cell to get at the parasites. All of the sulfonamide drugs we are considering enter the red cell to some degree as do the antiplasmodial agents atabrine and quinine. Penicillin does not penetrate the red cell to an appreciable extent.

When allowance is made for the fraction bound to plasma proteins, all these agents are probably distributed through most of the extracellular tissue fluids, which make up about 25 per cent of the body weight, in a concentration equal to that of the diffusible fraction in the plasma.

Cerebrospinal Fluid. The extracellular fluids of the central nervous system constitute a physiologically separate compartment from the rest of the extracellular fluids. The "blood-brain barrier" retards the entrance of many of these agents into the interstitial fluid of the central nervous system and the cerebrospinal fluid. Sulfanilamide and sulfapyridine enter readily, sulfadiazine and sulfamerazine less readily, and sulfathiazole hardly at all.

The readiness with which these agents enter the cerebrospinal fluid is directly proportional to the fraction of the plasma concentration which is free (*i.e.* not absorbed on plasma proteins), but this is not the only factor concerned. It has been demonstrated that the membrane separating the central nervous system from the blood can discriminate between organic molecules differing only slightly in chemical structure.

Penicillin does not penetrate the blood-brain barrier readily in either direction, indicating the advantage of intrathecal injection in meningitis. The same is true of streptomycin. The cinchona alkaloids enter the cerebrospinal fluid slowly but probably to eventual equilibrium with the diffusible fraction in the plasma, as does atabrine. It should be mentioned that with inflammation of the meninges all these agents pass more readily through the blood-brain barrier.

Penetration Into Tissue Cells. With regard to the intracellular compartment there are three ways in which a drug may behave: (1) it may be excluded from the cellular compartment; (2) it may diffuse into

the cellular water in a concentration equal to that in the interstitial fluid; (3) it may be specifically localized within cells. It seems probable that penicillin and streptomycin fall into the first category.

All of the sulfonamide drugs in common use penetrate the tissue cells; sulfanilamide, sulfathiazole and sulfapyridine apparently are localized or concentrated there to some degree, whereas sulfadiazine and sulfamerazine are distributed more as if they freely penetrate most cell membranes without being specifically localized within the cells. Quinine and atabrine are concentrated in the tissues to a marked degree.

The degree of their cellular localization varies with different tissues, being least in muscle and central nervous tissue and greatest in lung and liver. It is not yet certain whether this accumulation in the tissues represents a concentration gradient across the cell membrane or simply a combination of the drug with some indiffusible cellular constituent so that it is removed from free solution.

The problems of metabolic alteration and renal excretion will be discussed in the concluding section of this article to be published in the February issue.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Nylon Sutures

In the *British Medical Journal* (Jan. 6, 1945), Dr. Herbert Haxton describes his experiences with nylon sutures. He points out that nylon, being a synthetic product, is sterile when manufactured and cannot harbor organisms in its interior.

The author conducted a series of experiments on wounds in the abdominal walls of rats, sutured with nylon and with catgut and examined from two days to eight weeks after operation. The catgut sutured wounds were more inflamed and were edematous, were adherent to the overlying skin and in 10 per cent of them pus was present around the catgut. The wounds sutured with nylon healed rapidly and with a minimum of inflammation and fibrosis.

Three hundred operations were performed by the author on patients whose ages ranged from 12 hours to 91 years. In all cases nylon was used for buried sutures and ligatures, as well as for skin sutures. Even in the presence of infection (76 appendectomies, in many of which free pus was present) there was no tendency for the sutures or ligatures to be extruded. Wounds healed rapidly and soundly.

On several occasions, where a second operation was necessary, the nylon sutures used in the previous operation were found to have a minimum of surrounding fibrosis. The cases have been followed up for periods of from one to nine months and no symptoms referable to the buried nylon have been elicited.

Sterility of the sutures is achieved by immersion in boiling water for thirty minutes and for nearly all purposes the fine (No. 3) monofilament nylon prepared in 40 inch length is used; the strong (No. 5) is reserved for the ligation of large vessels and where there is tension. Because the "nylon knot" is tedious to tie and slips easily, the author employs a knot which is made by tying two half knots with one end—the long one—held taut. The ligature is run up tight and is locked by a third half knot tied with the short end held taut. Ends should be cut close to the knot.—JOHN F. CRANE.

When You Enlarge Recipes

ORPHA MAY HUFFMAN THOMAS
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Columbia University

THE hospital dietitian frequently wishes to make use of some favorite household recipe and wants to know whether it can be enlarged by applying simple arithmetic to the figures. The answer is that this can be done successfully if the proper procedure is followed exactly.

First, the recipe should be one that you think worth enlarging. If it is a family favorite, a recipe from a reliable source or one which incorporates an unusual idea or an attractive and palatable combination of foods, then it is worth the time and effort necessary to standardize it in the larger quantity.

Basic Recipes Easy to Enlarge

Second, you should make a careful study of the original recipe. Is it similar to a basic, tested recipe which you are now using? Many recipes vary from a basic recipe only in the seasonings or flavorings or the combination of foods in a basic sauce. If such is the case, it is much simpler to modify a basic recipe with which you are familiar than to enlarge a new formula.

Third, if the recipe is to be enlarged, it should be a reliable small-quantity recipe, accurate in every detail. Inaccuracies which may not be noticed in the small quantity produce errors when multiplied a number of times. An inaccuracy of 1/16 ounce in a recipe for four people produces an error of 1½ ounces when the recipe is enlarged for 100 people and this may make the difference between success and failure in the product. The small-quantity recipe must, therefore, be expressed in terms of weights for all dry ingredients before an attempt is made to enlarge it.

The reason for this is that there are many sources of error in the measuring of ingredients. Most recipes now encourage the use of the level measure rather than the heaped or rounded measure. The method of leveling may vary the amount of the ingredient appreciably. For example, the edge of a knife is often used as a leveling tool. If the edge of the knife is straight and is scraped over both edges of the spoon, a level measurement will result. But if the knife edge is convex and the blade is held perpendicular to the edges of the spoon, the material will be partially scraped out instead of leveled.

There are also wide variations in the amount of an ingredient measured in the same cup by different people. One person may call 3½ ounces of flour a cupful, while another packs in 4½ ounces to a cupful. One person may not sift before measuring, scooping up and packing the flour, while another sifts the flour carefully into the cup incorporating air or with equal care lifts spoons of sifted flour into the cup.

Measuring Utensils Vary

Measuring utensils also offer a chance for wide variation. Some cooks use tea or coffee cups and spoons from tableware sets as their measuring devices. Even if special measuring cups are used, all cups sold as measuring cups do not hold a standard cup which should contain 1/16 gallon, 14.44 cubic inches or 8 fluid ounces. One tablespoon should equal 1/16 cup or ½ fluid ounce and one teaspoon should equal ⅓ tablespoon or 1/48 cup.

Some cups and spoons have extra flanges to prevent spilling and to aid in pouring. There is a tendency to fill or partially fill such a flange and this should not be done.

All these factors are evidence that ingredients should be weighed instead of measured. Accurate scales, which are easily used and read, are a *must* for changing the measurements of the small recipe to weights.

The exception to the use of weights may be the liquid ingredients. Liquids are frequently measured in both large and small recipes. If, however, liquids are to be measured rather than weighed, be sure to have the proper sized measuring utensils for your job, such as standard pint, quart and gallon measures. Fewer errors result from measuring an ingredient as one quantity than from measuring a number of cups, one cup at a time.

The fourth step in enlarging a recipe is to multiply the measurements of the small recipe to the desired size.

Translate Enlarged Measurements

Fifth, translate these measurements into the appropriate terms. If 6 ounces of flour in the original recipe have been multipled by 25 to produce the required amount, write the new recipe as 12 pounds 6 ounces, not as 150 ounces. If 3 cups of liquid have been multiplied by 4, state the liquid as 3 quarts, not as 12 cups.

Sixth, although such a reminder seems almost unnecessary, arithmetic must be checked for the errors we all make at times. Be sure your mathematics is correct. An excellent way to do this is to have some other person make the computations and compare her results with yours. Stenographic errors are easy to make, especially if the typist is not trained as to the importance of accuracy. Having the typist initial the recipe, to signify that she proofread the formula, makes her feel responsible.

Seventh, check the final quantities of ingredients to see that they meet the required proportions for the particular type of product. Many cookbooks give general proportions for typical products. The quantities

should not vary markedly from a standard formula.

Eighth, season with care. It is always easier to add than to remove. Add part of the calculated amounts of the seasonings and then taste. Add the remainder, as needed. Many seasonings vary in strength according to source and age.

Ninth, make a point of doing experimental work on a slack day or when other work is less urgent. An established day for making trials encourages you to introduce new items and conditions the employes to expect such trials. If Saturday is a slack day, try a new recipe on that day. It is always wise to try a new recipe before using it for a special event.

The experiment can also be used as a morale builder. Try the new recipe in a size which can be used for the employes' meal. Ask and respect their opinions regarding the desirability, practicability and salability of the product.

What's Cooking In Electronics?

LET'S say it's the year 1956. One of Superintendent Smith's snappily uniformed volunteers is conducting you and me on a tour of Centerville General Hospital, the occasion being an Open House for the new building said to be Modernism Minus Nothing.

"And this is the broadcasting room?" you remark knowingly as we enter a small area equipped with instruments controlled by dials and push buttons.

"No, Madam. The broadcasting room is on the roof." And here the volunteer's graciousness is colored by the faintest tint of superiority: "This compact little room is the kitchen."

"You don't mean to tell me that you can feed 300 patients and the same number of employes from this little flameless, heatless, windowless hole? Have we come to capsule rations at last? Excuse me from that," I reply with more asperity than her quiet air of superiority really warrants.

Same Menus, New Kitchen

"On the contrary, the menus will be conventional—all the usual general and special diets. This, you see, is an electronic kitchen."

Perhaps 1956 is too early a date; perhaps the electronic kitchen may come even sooner. The two chief stumbling blocks are high costs and some technical difficulties. It is now possible to cook a steak by electronic heating in five seconds but to accomplish this requires $12,000 worth of electronic equipment.

Alberta M. Macfarlane, educational director of the National Restaurant Association and an occasional contributor to The Modern Hospital, is preparing the restaurant field for electronic heating of foods. In the News Letter of the National Restaurant Association for December 1, which she edits, she predicts that the pressure and tension will be taken out of quantity food production when the day of electronic heating on an institutional level dawns, as all cooking will be easier and quicker.

Quoting W. B. Urbain of Swift's research laboratories on the subject: "Electronic heating now offers a fundamentally new process of heating. Instead of conducting heat in, as is done by conventional methods, electric energy is converted to heat within the object being heated. The converter is a special piece of electronic equipment not vastly different from the radio broadcasting transmitter. It utilizes ordinary electric power and delivers high frequency current which is changed to heat."

One advantage of electronic cooking is speed; hours are shortened to minutes and minutes to seconds. Because the heat is generated within and not conducted in, all parts of a product of similar structure can be heated uniformly.

"From an esthetic point of view, this new type of heating may not always be advantageous," Miss Macfarlane points out. "The loaf of bread is left white, not golden brown on the crust; the broiled fish is pale and hence does not have an appetizing appearance; the roast of beef is minus that tempting, crusty, much desired outside slice.

"Difficulties, too, are experienced in broiling meat owing to the difference in the structure of the fat and the lean. The fat is likely to burn while the muscle parts are not completely cooked."

In time, Miss Macfarlane believes these difficulties may be overcome.

On the credit side, hamburgers and frankfurters, those stand-bys in the feeding of employes, are cooked to the queen's taste and in the twinkling of an eye. Doughnuts put through an electronic field are done in short order.

Heat Confined to Object Cooked

Advantages of electronic heating other than speed and uniformity, as cited by Miss Macfarlane, are the confinement of heat to the object being heated (making for a cool kitchen), compactness of equipment (saving valuable cubage) and cleanliness of operation.

Restaurant managers are told of a vending machine for sandwiches, which has been in operation for two years but is not yet on the market, which turns out hot sandwiches before the eyes of the purchaser.

Meat, cheese or other fillings drop with the bread into a transparent cylinder, which is the heating chamber. Current passing through the coil, spiraling around it from the electronic tubes on either side, sets up a high frequency within the cylinder.

The resistance offered by the sandwich generates heat which cooks the meat, cheese or other filling evenly throughout its bulk.

In a few seconds the sandwich is ejected kitchen fresh, piping hot and completely sanitary as it is wrapped in a dustproof, moistureproof wrapper which prevents contact with hands or machine prior to its being served to the purchaser.

"Just as the electric eye door was once a novelty and has now become a commonplace, other electronic devices, which at present are only filaments of the future, will be our servants tomorrow," Miss Macfarlane states. "One electronic device will free our institutions of dust as each particle will be drawn away on an electrically charged plate as it enters the premises.

"Refrigerators will be equipped with electronic instruments that will assist in the preservation of foods, especially meats. Lighting in general in hospital kitchens will be fluorescent, by means of electronic tubes.

"Electronics will also be applied to packaged flour and cereal to destroy molds or insects. It may also be a means of preserving the texture and vitamin content of frozen or dried vegetables."

Higher Nutritive Value Possible

The blanching of vegetables by electronic heats points the way to production of processed fruits and vegetables of higher nutritive value.

"It is generally recognized that a preliminary heat treatment of raw vegetables to destroy enzymes is required to prevent deterioration of flavor, color and certain vitamins during storage in the frozen or dehydrated state," says *Nutrition Reviews* for November.

"The commonly used boiling water or steam blanching often damages the desired texture of the product and leaches out considerable of the soluble vitamins. The internal heating provided by electronic power cooks a vegetable, so to speak, 'in its own juice.'

"In their preliminary report, Moyer and Stotz have demonstrated that the 30 to 40 per cent loss of ascorbic acid encountered during steam and water blanching of shredded cabbage was reduced to a negligible 3 per cent by electronic blanching. Further studies with other products are promised."

Forecast on Foods: *Frozen and Dehydrated*

ONE reads admiringly of frozen precooked foods heated for serving in "whirlwind ovens" and wonders what such developments presage for the hospital kitchen.

Among other branches of the armed services, the Naval Air Transport Service made excellent use of these war-time developments. The Bureau of Medicine and Surgery of the Navy Department assisted the N.A.T.S., Atlantic Wing, in developing frozen meals for flight feeding and by April 8, 1945, all transatlantic flights were serving meals that included steaks, carrots and French fries, veal stew and the like. It was early found that creamed foods were to be avoided since the process of separation takes place under quick-freezing. Gas-producing foods also were soon eliminated from the flight meals.

To fill the needs of evacuation squadrons flying wounded men back from the Pacific Theater of Operations, one manufacturer constructed a plant with the capacity of 25,000 meals a day. A part of the equipment aboard each evacuation plane was a "whirlwind oven," an aluminum box which operates on a thermodynamic principle to bring food from a temperature of 20° to 145° F. in fifteen minutes. One of the difficulties in food service on the N.A.T.S. planes was the need to bring all components of the meal—meat, vegetables and potatoes—to the required serving temperature quickly without their appearance, consistency or edibility being changed.

This goal was achieved and the N.A.T.S. ovens are now thermostatically controlled and electrically timed to prepare meals without attention by personnel. A timer bell rings at the end of each heating period to indicate that the meals are ready to serve.

These Navy meals, cooked weeks or months in advance, were quick-frozen on specially processed paper plates. The plates look like chinaware and are not touched by human hands, the Navy *Medical Bulletin* points out. Baffles fit over the vegetable and potato sections of the plate and help retain the necessary moisture in these foods.

Possibilities in Precooked Meals

Few hospital dietitians are willing to hazard a guess as to what use the hospital of the future will make of precooked foods or precooked meals. The housewife, particularly the woman in business, will be willing to pay well for precooked whole meals or individual dishes to stock the cold storage unit which she expects to own in the near future.

Large scale processing may bring such meals to a reasonable figure and, if so, they would take the terror out of hospital kitchen crises, such as interruptions in gas or electricity supply, an employes' strike or a fast hitting epidemic. At least the dietitian will soon have available to her certain precooked items like beef stew and other meat dishes on which she can base the menu when the chef fails to appear after a holiday binge.

Are hospitals of the future likely to do much in the way of quick-freezing on the premises? Will they do more or less home canning?

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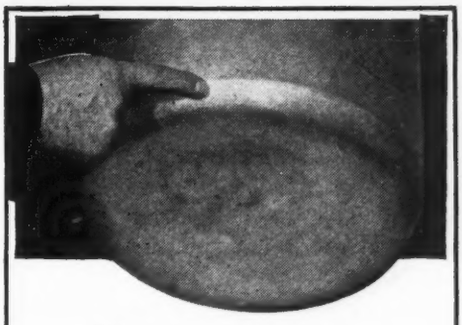


This spoon-fitting corner is another Wear-Ever feature

Unretouched photo of hard alloy, Smoothard surface, Wear-Ever Heavy Duty Stock Pot, after *four years* hard daily service in the McGraw-Hill kitchens. Note the generously rounded bottom edge that makes it easier to use and easier to clean.

Now... MORE WEAR THAN EVER IN—

WEAR·EVER ALUMINUM

Do frozen foods as they exist commercially today have increased appeal to dietitians? Are they making use of the various dehydrated foods which were developed so rapidly under war necessity?

To find the answers to these more immediate questions, a spot survey was recently made. The results were much as was anticipated.

Dietitians do not anticipate the development of home processing of foods in the hospital kitchens. They do not favor it, for the most part.

Frozen foods appeal to them greatly. With the exception of powdered milk and dried fruits, they prefer to have little or nothing to do with dehydrated foods at their present stage of development. Some of them have not given dehydrated foods a trial; those who have are apparently not enthusiastic.

Let's study a few of the responses.

Emily Leigh
San Jose Hospital
San Jose, Calif.

Ours is a 140 bed private institution and at the present time space is very limited. Even though we did have space available for freezing and canning foods, I do think it would not be advisable because experienced personnel would have to be obtained, equipment would probably be difficult to purchase and I do not believe it would be advisable in the long run.

Frederica D. Everitt
Formerly of
Hahnemann Hospital
Philadelphia

It is not feasible or economical for a hospital or institution to freeze or can food that it must buy. A hospital or institution that grows its own fruit and vegetables probably is justified in canning the surplus. As to whether it is safe would depend upon having proper equipment and a properly trained or experienced person in charge. Adequate help would be another factor.

Mary W. Northrop
King County Hospital System
Seattle, Wash.

I know of no one in this vicinity who is doing any quick-freezing in hospitals, nor do I see any reason why they should, any more than I see any reason for canning in a hospital. Both are highly technical processes.

What Foods Are Most Satisfactory?

Asked if they expected to make increasing use of commercially frozen and dehydrated foods and, if so, what foods in each category have proved most satisfactory in quality and most popular with patients and employes, these dietitians replied as follows.

Mabel M. MacLachlan
University of Michigan Hospital
Ann Arbor

Yes, we expect to make increasing use of commercially frozen food products. The items most popular with us are peas, corn, asparagus and lima beans. The university is planning a food administration building which will include increased space for frozen foods. We do not plan to use dehydrated foods.

Eva F. Hunt
Margaret Pillsbury General Hospital
Concord, N. H.

We are using commercially frozen food products quite extensively and shall probably do so increasingly. We cannot look forward to any increase in storage space until our new hospital is built.

Most of the frozen foods we have enjoyed, especially peas, strawberries, raspberries, pineapple and spinach.

We have had practically no experience with dehydrated foods.

Shirley Wells
Assistant Dietitian
Massachusetts General Hospital
Boston

We expect to make increasing use of commercially frozen food products in this hospital. They save a very appreciable amount of labor and cooking time, compare favorably in cost with fresh and canned foods and provide standard yields.

The frozen foods that we use in large quantity include peas, various kinds of beans, peaches, blueberries, cherries and other fruits used in the bake shop; also frozen egg yolks and egg whites.

We have experimented with several dehydrated foods some of which we like very much and others not at all. The only dehydrated product that we consistently use in great quantity is powdered milk.

Capt. Mildred Allbritton
Fitzsimons General Hospital
Denver

Twelve years ago when frozen foods were made available for institutional use in this area, we were the first to use them in large quantities. Throughout these years, we have used increasingly more as different brands and new products appeared on the market. Our institution has several large freeze units. We do not contemplate adding more at this time.

We have used dehydrated foods for experimental purposes only. We do not contemplate using them to a great extent.

Rita E. Black
John Sealy Hospital
Galveston, Tex.

I have found frozen foods very valuable. They make a plate more attractive and the flavor is good. I expect continually to increase the amount used.

I have used very few dehydrated foods and as yet have not tried any that were entirely satisfactory.

Research Under Way

So much for the hospital dietitians' views at the present time. The picture will keep changing, however. The Refrigeration Equipment Manufacturers Association recently surveyed 100 colleges and universities to determine the extent of their activities in the field of frozen foods. More than half of these universities are either conducting frozen food experiments or planning such experiments.

The University of California is seeking the proper method of freezing fruit juices so a housewife or a hospital with a farm can store up juices during the peak production periods.

At the University of Wyoming the emphasis is on eggs. If its research workers can eliminate the gumminess in yolks of eggs held in storage this will be of dollars-and-cents value to hospitals.

Louisiana State University is at work on freezing processes for shrimp and other sea foods. At Illinois and Missouri the freezing of meats and poultry are under experiment. Texas Technological College is experimenting in the freezing of entire meals and combinations of foods to enable the dietitian or housewife to prepare well-balanced menus far in advance. With plenty of food in the frozen foods unit, the cook's day off would not present such a problem in small institutions.

Menus for February 1946

Gretchen Poland
Worcester Hahnemann Hospital
Worcester, Mass.

1
Sliced Oranges
Scrambled Eggs
•
Tomato Soup
Baked Haddock Fillets
Creamed Potatoes
Spinach
Lettuce, Chiffonade Dressing
Lemon Snow With Custard Sauce
•
Macaroni and Cheese
Pineapple and Grape Salad
Spice Cup Cake

2
Baked Apples
Bacon Curls
•
Vegetable Broth
Swiss Steak
Whipped Potatoes
Buttered Carrots
Waldorf Salad
Gingerbread With Whipped Cream
•
Goldenrod Eggs
Molded Fruit Salad
Butterscotch Cookies

3
Grapefruit Halves
Coffee Ring
•
Cream of Mushroom Soup
Broiled Chicken
Candied Sweet Potatoes
Peas
Cranberry Salad
Ice Cream
•
Oyster Stew
Orange and Stuffed Prune Salad
Brownies

4
Tomato Juice
Boiled Eggs
•
Consommé
Roast Lamb
Whipped Potatoes
Green Limas
Pear and Mint Jelly Salad
Sponge Cake, Orange Marshmallow Sauce
•
Escalloped Corn With Chopped Bacon
Stewed Plums
Oatmeal Cookies

5
Orange Juice
French Toast, Maple Sirup
•
Cream of Asparagus Soup
Broiled Meat Balls
Baked Potatoes
Escalloped Tomatoes
Green Salad
Date Tapioca
•
Chipped Beef on Toast
Jellied Fruit Salad
Applesauce Cake

6
Grapefruit Halves
Poached Eggs
•
Scotch Broth
Chicken Pie With Vegetables
Hubbard Squash
Lettuce, Russian Dressing
Toll House Bread Pudding
•
Spanish Omelet
Canned Peaches
Silver Nut Cake

7
Apricot Nectar
Cinnamon Buns
•
Cream of Pea Soup
Baked Ham
Escalloped Sweet Potatoes
Broccoli
Perfection Salad
Coffee Ice Cream
•
Corn Chowder
Fruit Salad Plate
Devil's Food Cake

8
Chilled Grapes
Scrambled Eggs
•
Clear Tomato Soup
Baked Halibut
Whipped Potatoes
Buttered Beets
Lettuce, French Dressing
Lemon Meringue Cake
•
Deviled Egg Salad Plate
Apple Crisp

9
Orange Sections
Baking Powder Biscuits, Honey
•
Cream of Celery Soup
Roast Beef
Browned Potatoes
Wax Beans
Raw Carrot and Apple Salad
Rice Pompadour
•
Italian Spaghetti
Salad Bowl
Banana Nut Cake

10
Grapefruit Halves
Corn Bread, Orange Marmalade
•
Fresh Fruit Cup
Roast Chicken With Stuffing
Whipped Potatoes
Acorn Squash
Cranberry Relish
Butterscotch Sundae
•
Sandwich Loaf
Pear and Stuffed Date Salad
Orange Cup Cakes
Cocoa

11
Stewed Prunes
Omelet
•
Noodle Soup
Beef Stew With Vegetables and Dumplings
Tossed Salad
Coffee Bavarian Cream
•
Chicken Broth
Toasted Tomato, Bacon and Lettuce Sandwich
Butterscotch Pudding, Whipped Cream

12
Sliced Oranges
Bacon Curls
•
Tomato Juice
Broiled Lamb Chops
Au Gratin Potatoes
Spinach Timbale
Celery Hearts
Chocolate Logs
•
Cheese Rabbit
Asparagus Log Cabin Salad
Sponge Cake

13
Sliced Bananas
Soft Boiled Eggs
•
Lentil Soup
Baked Ham Loaf With Raisin Sauce
Hashed Brown Potatoes
Green Beans
Lettuce Hearts
Apple Pie
•
Escalloped Vegetables With Cheese Topping
Apricots
Coconut Layer Cake

14
Honey-Baked Apples
Sweet Rolls
•
Tomato Bisque
Chicken Shortcake on Biscuit Hearts
Paprika Potatoes
Broccoli
Red Gelatin Heart Salad
Strawberry Sundae
•
Consommé
Assorted Sandwiches
Valentine Salad
Heart Cookies

15
Pineapple Juice
Scrambled Eggs
•
Cream of Potato Soup
Fish Cakes With Egg Sauce
Tomato Salad
Hot Rolls
Lemon Chiffon Pie
•
Tuna Salad
Potato Chips
Stuffed Celery
Chocolate Pudding
Drop Cookies

16
Orange Juice
French Toast, Maple Sirup
•
Beef Broth
Roast Lamb
Whipped Potatoes
Peas
Carrot and Celery Strips
Rice and Raisin Pudding
•
Baked Potatoes With Creamed Chipped Beef
Orange and Stuffed Prune Salad
Cottage Pudding

17
Bananas and Pineapple Juice
Swedish Coffee Bread
•
Cranberry Juice
Broiled Chicken
Riced Potatoes
Hubbard Squash
Currant Jelly
Butterscotch Sundae
•
Cream of Celery Soup
Peach and Cottage Cheese Salad
Peanut Cookies

18
Prune Juice
Soft Boiled Eggs
•
Cream of Asparagus Soup
Roast Veal
Baked Potatoes
Escalloped Tomatoes
Grapefruit Salad
Spanish Cream With Chocolate Meringue
•
Welsh Rabbit
Molded Fruit Salad
Pineapple Upside-Down Cake

19
Sliced Oranges
Bacon Curls
•
Vegetable Broth
Meat Loaf With Creole Sauce
Creamed Potatoes
Brussels Sprouts
Salad Bowl
Devil's Float
•
Veal Paprika With Noodles
Fruited Gelatin
Cornflake Macaroons

20
Bananas
Poached Eggs
•
Tomato Juice
Chicken Chop Suey With Fried Noodles
Waldorf Salad
Apricot Upside-Down Cake
•
Goldenrod Eggs
Asparagus Salad
Fruit Tapioca

21
Applesauce
French Toast, Maple Sirup
•
Barley Soup
Roast Beef
Whipped Potatoes
Spinach With Lemon Slice
Celery Hearts
Prune Whip With Custard Sauce
•
Sweetbreads and Mushrooms
Lettuce With Russian Dressing
Mocha Cake

22
Grapefruit Juice
Scrambled Eggs
•
Tomato Soup
Baked Blue Fish
Whipped Potatoes
Green Beans
Vegetable Salad
Washington Pie
•
Corn Chowder
Cherry Salad
Hatchet Cookies

23
Prune Juice
Bacon Curls
•
Cream of Celery Soup
Braised Beef
Riced Potatoes
Harvard Beets
Perfection Salad
Glorified Rice
•
Browned Beef Hash
Escalloped Tomatoes
Banana Cream Pudding Layer Cake

24
Orange Juice
Poached Eggs
•
Grape Juice Cocktail
Chicken Shortcake
Glazed Sweet Potatoes
Green Peas
Cranberry Jelly
Ice Cream Puffs
•
American Chop Suey
Coleslaw
Canned Pears
Chocolate Cake

25
Applesauce
Baked Sausages
•
Cream of Pea Soup
Swiss Steak
Whipped Potatoes
Carrot and Celery Strips
Broccoli
Peach Custard
•
Beef Broth
Baked Rice and Cheese
Date Salad
Coconut Bars

26
Pineapple Juice
Soft Boiled Eggs
•
Cream of Asparagus Soup
Grilled Lamb Patties With Apple Slices
Baked Potatoes
Harvard Beets
Pumpkin Chiffon Pie
•
Oyster Stew
Cooked Vegetable Salad
Prune Whip Cake

27
Apricot Juice
Griddle Cakes, Sirup
•
Scotch Broth
Veal Cutlets
Escalloped Potatoes
Buttered Parsnips
Cranberry Upside-Down Cake
•
Baked Eggs in Mashed Potato Nests
Grapefruit Salad
Fruit Gelatin

28
Sliced Bananas
Scrambled Eggs
•
Cream of Vegetable Soup
Broiled Lamb Chops
Parsley Buttered Potatoes
Cauliflower
Raw Carrot and Raisin Salad
Boston Cream Pie
•
Codfish Balls With Creamed Peas
Tossed Salad
Applesauce Cake With Butter Icing
Canned Loganberries

Ready-to-eat or cooked cereals are offered on all breakfast menus.

How to Use DDT

ALFRED WEED
New York City

THE discovery of the insecticidal value of dichloro diphenyl trichlorethane (DDT) by Müller is an impressive addition to the evergrowing list of materials used to combat insects. Although not available to civilians until late last summer, a substantial amount of information has been developed by the U. S. Department of Agriculture, state experiment stations and other agencies dealing with its use in insect control. During the last two years this compound has held the entomological spotlight, and rightly so, because of its importance in destroying disease-carrying insects among our armed forces.

Paralytic Action Slow

The principal characteristic possessed by DDT, aside from its ability to kill a wide variety of pests, is the persistence of its deposits upon surfaces to which it has been applied. This property produces results which are truly spectacular when it is used against some of our household pests. The paralytic action of the compound is slow in comparison to that of pyrethrum and the thiocyanates.

The compound, while practically insoluble in water, is soluble in light petroleum oils, such as have been used in liquid insecticides for years. In oils of this type, an adjuvant solvent may be needed to maintain satisfactory solutions at low temperatures. Insects are killed by the compound upon contact with it whether it is applied directly to them as a dust or spray or whether surfaces are treated with which they subsequently have adequate contact.

The compound by itself is of little value. DDT must be in solution, preferably in an insecticide base oil for indoor spray use or as an emulsion diluted with water or a wettable spray powder that can be added to water. Because of the physical characteristics of the material, it is difficult to grind and must be milled in conjunction with some inert substance, such as talc or clay. The wettable powder can be produced at the time of grinding through the addition of a small amount of a wetting or dispensing agent. All of these compositions have become available during the last two months ready to fit into the unfolding program of DDT use.

Many insecticide manufacturers have moved slowly with DDT because it is a toxic compound. While this attitude may be ridiculed by some and the hazard surrounding DDT may prove of less magnitude as additional experience is gathered, caution in its use appears advisable at present. If large amounts of the compound are eaten, it is poisonous and among the numerous laboratory animals studied, many showed accompanying liver injury. In solutions it is absorbed through the skin. Therefore, precautions should be taken to keep such contact to a minimum.

Should Not Be Applied to Foods

While no human being has been known to die from the effects of DDT, it has produced toxic symptoms in at least one case. Under the circumstances, insecticides containing DDT should not be applied to foods; excessive amounts of sprays or dusts in which DDT is an ingredient should not be ingested or inhaled and lengthy or repeated contact of solutions of DDT with the skin should be avoided.

It is most appropriate that the public and the bulk consumer of insecticides of the household spray type understand that DDT can be effectively used in two ways: (1) as a residual deposit preparation and (2) through the addition of a relatively small amount of the compound as a conventional contact "space spray."

As a general purpose spray, the latter product is preferable since such sprays are fast acting and their performance against household pests is materially improved through the inclusion of small amounts of DDT.

Recent publicity dealing with the use of this compound by civilians has consistently pressed for 5 per cent concentrations. There already exists substantial evidence that this amount of DDT is unnecessary in residual deposit sprays for several common pests.

For Surface Applications

Much of the work with residual sprays involves surface coatings of from 100 to 200 milligrams of DDT per square foot of surface. The lower amount is obtained with 4 cc. of a 2½ per cent DDT solution applied per square foot or half this amount of a 5 per cent solution. Surface applications can be made with any convenient spraying equipment or with a brush. A fine wet spray is recommended; it should be applied from a little distance so as to moisten the surface but should not be liberal enough to run. It is doubtful whether such surface treatment with a residual type of spray is practical for home use, except where the deposit will not be objectionable. It is not advisable to apply such a spray to wallpaper or to dark finishes.

Although better residual properties are attributed to the wettable powder sprays and to the emulsions, the oil solutions are preferred where heavy deposit and water spotting would be undesirable.

In combating flies, mosquitoes and gnats indoors, apply a residual spray

in oil to light fixtures and surfaces in their immediate vicinity, if painted, to light drop cords, to window and door frames, to painted ceiling and wall areas where fly specks are seen or where flies and mosquitoes are observed. Treat screens, screen doors, door and window frames and trim, porch columns and ceilings. When making applications, foods, cooking utensils and dishes should be put away or covered. When quick destruction of flies and mosquitoes is necessary, recourse should be made to a conventional contact space spray.

Another outstanding use for DDT is to kill bedbugs, not only through direct contact when applied as a spray, but by means of residual deposit. A single thorough treatment with an oil solution of 2 to 5 per cent of the compound of bed, springs and mattress gives control lasting for many months.

In applying a spray containing DDT, particular attention should be given to all cracks and joints in a bedstead. Treat the springs and both sides of the mattress. Three or four ounces are adequate for a full-sized bed. It is also advisable to spray baseboards and cracks and crannies in woodwork and behind moldings as these places of concealment are frequently sought by the bugs.

The value of DDT insecticides for controlling roaches is still being debated. Numerous practical tests have been made with both liquid and powder treatment and there remains some diversity of opinion. Roach infestations have been cleaned up nicely with thorough applications of 10 per cent DDT powder but a frequent criticism is made that results are a little slow and that populations treated have a tendency to scatter. Liquid spray deposits, liberally applied, are reported to reduce greatly the number of roaches if ample time is allowed.

Infestations of fleas are reported controlled with oil sprays containing 1 to 2 per cent of DDT or they can be handled with a powder containing 5 to 10 per cent of DDT. Some species of ants are controlled with a residual spray containing 5 per cent of DDT. For protecting woolens from moths and carpet beetles, a 2 per cent solution in oil appears promising. Several other household insects can be combated with DDT but further data are needed before recommendations can be made.

Insecticides containing DDT are here to stay unless they are replaced in the future by a superior compound.

How to Care for Walls

From Thomas A. Hawkins of Wayne University comes sound advice regarding the treatment of walls:

"The main part of painting is preparing the surface to be painted. The wall must be clean to get a satisfactory result. After the paint is dry, make a thin solution of cornstarch and paint the wall with it. It will keep your paint from fading and will facilitate washing.

"It is important what you use to wash a wall; otherwise you will do more harm than good. You should use an oil base soap, but you are not always able to get it nowadays. Almost any good soap powder will do if you use it properly. It is a wise plan to put some of the powder in a pail of water and wash your hands in it. If they burn and smart, it is because the powder has taken the oil out of your skin. It will do the same to the paint. If your hands do not burn, you can know that the powder will not hurt the wall."

With Prevention in Mind

CHARLES J. ANDERSON

Chief Engineer and
Supervisor of Maintenance
Crouse-Irving Hospital, Syracuse, N. Y.

IN THE maintenance department of Crouse-Irving Hospital, Syracuse, N. Y., we have instituted an inspection program that anticipates and prevents many service calls and tends to keep the mechanical setup of our hospital in excellent working order.

Each Saturday is set aside as inspection day. One man checks elevators (we do our own elevator maintenance) and refrigeration; another takes such equipment as sterilizers and resistors, and so on down the line to wheel chairs and stretchers. Our electrician inspects every motor for brush and commutator wear and any other trouble.

We have devised a metal tool box that contains everything needed for repairs to toilets, lavatories, showers and bathtubs. One man takes this box and starts at the top floor and comes all the way down, checking and repairing everything in this line. If this is done routinely each week, it takes surprisingly little time. Each man makes small repairs to the equipment he inspects and reports what he has done and also any further repairs that may be needed.

This inspection program, if followed weekly, takes a very short time and prevents many repair calls throughout the week. For example, let us take the matter of faucets, valves, bathtub and lavatory stoppers and chains. If they are handled on a weekly inspection and repair schedule, one man can come down through the building doing the whole job. If they are handled by individual call when needed, this man must get his equipment for each call and either walk several flights of stairs or wait for an elevator, which usually takes as much time as the repair job, and then must lose the same amount of time getting back to his starting place. Furthermore, in a few hours he may get another request to do a similar job on the same or the next floor when he must again get his equipment and wait for an elevator to do a job that could have been done on the first trip.

Arthur Bristol, assistant engineer, demonstrates the usefulness of the plumbing fixture box in making repairs to a leaking faucet.

This system of routine inspection works equally well in the power plant where we generate both our steam and our electric power. The day and night crews are assigned certain duties which are performed on a definite schedule.

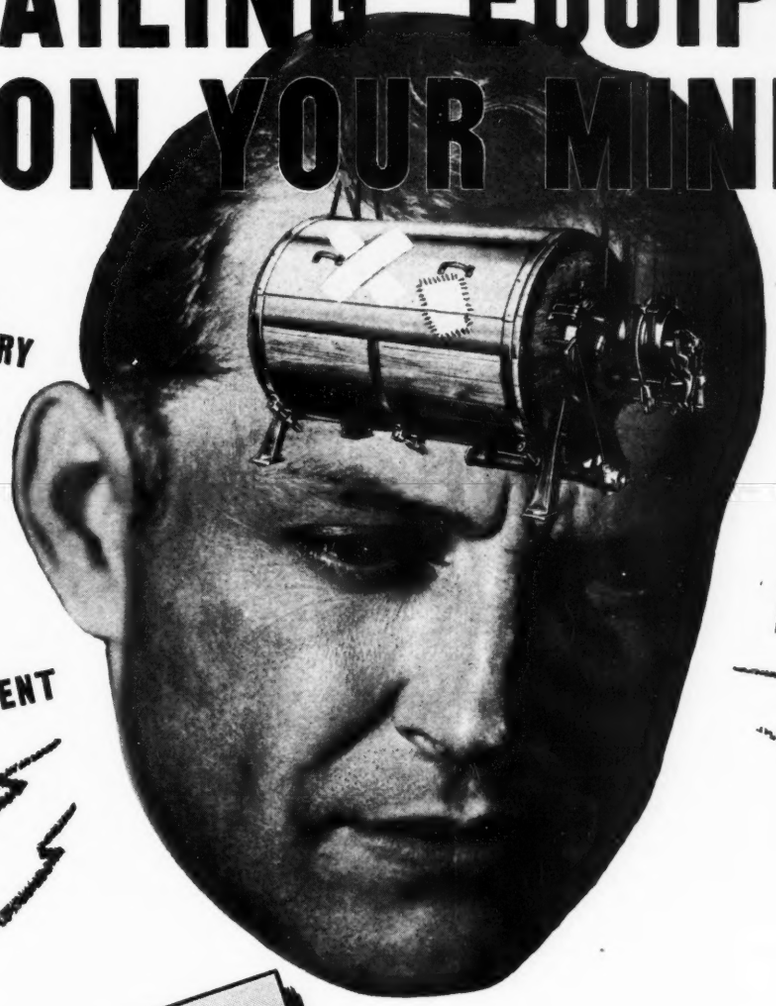
For example, the night crew (midnight to 8 a.m.) is responsible for changing filter socks on the boiler feed line grease extractors every tenth night; it is also responsible for changing oil on the Ridgeway engine every two weeks.

The men on the 4 p.m. to midnight shift take care of the greasing and lubrication of the stokers and also change over the generating units. These two crews are also charged with cleaning the power plant floors and wiping the machinery that is down. These jobs are alternated weekly, *i.e.* one week the afternoon shift cleans the floor while the night men wipe down the machinery, and the next week these duties are reversed.

The day crew is charged with cleaning boilers and changing them over when necessary and with keeping tubes blown out. All three firemen are required to spend ten minutes out of each shift keeping the tops of the boilers clean.

We have found that if each man or crew is charged with special duties we get a much better job done and everyone is happy.

IS "AILING" EQUIPMENT ON YOUR MIND?



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NEWS IN REVIEW

Milwaukee County Board Investigates Charges Made by Interns, Residents

Investigation of the management of Milwaukee County General Hospital at Wauwatosa, Wis., following charges of neglect and inefficiency by a group of interns and resident physicians, has revealed the opinion of outside experts that the hospital is clean and well managed and that delays and failures to produce needed supplies and equipment have been only those suffered by all hospitals during the war-time emergency.

The investigation was precipitated last month when protesting house staff members struck as an expression of discontent, refusing to answer telephone calls to interns' quarters, to sign discharges of patients ready to leave the hospital or to obtain consent for autopsies. A full hearing before the county's board of public welfare, which operates the 1050 bed institution, was ordered as a result of the formal charges of incompetence filed by the striking group.

Claiming at first that patients were suffering and even dying as a result of the management's failure to provide needed equipment and service, the intern-resident group, led by Dr. Howard D. Trimpi, later sought to retract the charge that any deaths had resulted directly from inefficiency. However, William L. Coffey, manager of county institutions, Dr. Harry W. Sargeant, superintendent of the hospital, and members of the medical staff requested that the original charge be allowed to stand so that the protesting interns and residents could be held accountable for statements made publicly against the hospital's administrative and medical staffs.

Called in as an expert witness because of his familiarity with conditions in hospitals all over the country, Everett W. Jones, vice president of The Modern Hospital Publishing Company, told the county board at one of its public hearings that Milwaukee County "ranks way up among county hospitals and compares favorably with private hospitals" in cleanliness and efficiency. At the request of the board, Jones made an inspection tour of the hospital in company with Joseph G. Norby, administrator of Columbia Hospital, Milwaukee, and members of the Milwaukee County staff, including Doctor Trimpi. It was immediately apparent as a result of the inspection, Jones said, that most of the charges were exaggerated and many were completely unfounded.

Disputes between the hospital management and the resident group started several months ago with a request for additional telephones for the interns' living quarters and more adequate meals for staff members on night duty. Failure to provide these ultimately led to the intern-resident strike, at which time the group also charged that the hospital failed to provide adequate laboratory facilities for doctors and needed drugs for patients, that shortages of linens, bedpans and urinals made conditions in many wards insanitary, that the hospital had no adequate blood bank, that needed medical supervision of the transfer of patients from the emergency department to the hospital proper was lacking and that the hospital failed to encourage medical research.

Answers brought out by Doctor Sargeant and other members of the hospital staff denied that any patients had suffered or died because of neglect and asserted that the sanitary conditions cited in the charge were due entirely to the preponderance of incontinent patients in the wards under discussion and not to lack of facilities or personnel. Other shortages that existed were consistent with those experienced elsewhere during the war years, it was claimed.

Mental Health Bill Reported

WASHINGTON, D. C.—The House Interstate and Foreign Commerce Committee has reported out favorably the Mental Health Institute Bill sponsored by J. Percy Priest of Tennessee. The proposed legislation would establish a national mental health institute at Bethesda, Md., to be administered by the U. S. Public Health Service. A sum of $4,500,000 is authorized for the establishment of the institute. The bill authorizes the Public Health Service to make grants-in-aid to universities, hospitals, laboratories and other public and private institutions for research projects.

Speed Veterans' Rehabilitation

WASHINGTON, D. C.—A reconditioning service designed to integrate treatment by physical therapy, occupational therapy and industrial therapy has just been established in the Veterans Administration. The new program, headed by Lt. Col. Donald A. Covalt, will speed total rehabilitation of disabled veterans. The reconditioning service plan calls for a continuous program of treatment for the patient in a suitable field of therapy.

Advocates Removing Control of Licensure From Nurse Board

By EVA ADAMS CROSS

WASHINGTON, D. C.—Proposals to strip the District Nurses' Examining Board of control over the nursing profession were made during recent hearings on a proposed bill to license practical nurses.

The bill submitted by the Graduate Nurses' Association would require all men and women to obtain a $10 a year license from the Nurses' Examining Board in order to engage in any form of practical nursing. No opposition was made to the principle of the licensing bill to impose standards of practice on the practical nurse group.

Commissioner Guy Mason, however, voiced his opposition to the powers of the Nurses' Examining Board. He claimed that all licensing and accrediting should be transferred to the District Commission on Licensure, responsible for licensing doctors. He released a petition from Dr. Edgar P. Copeland, member of the board of Children's Hospital, advocating such a transfer on the ground that nurses should not control their own standards and requirements.

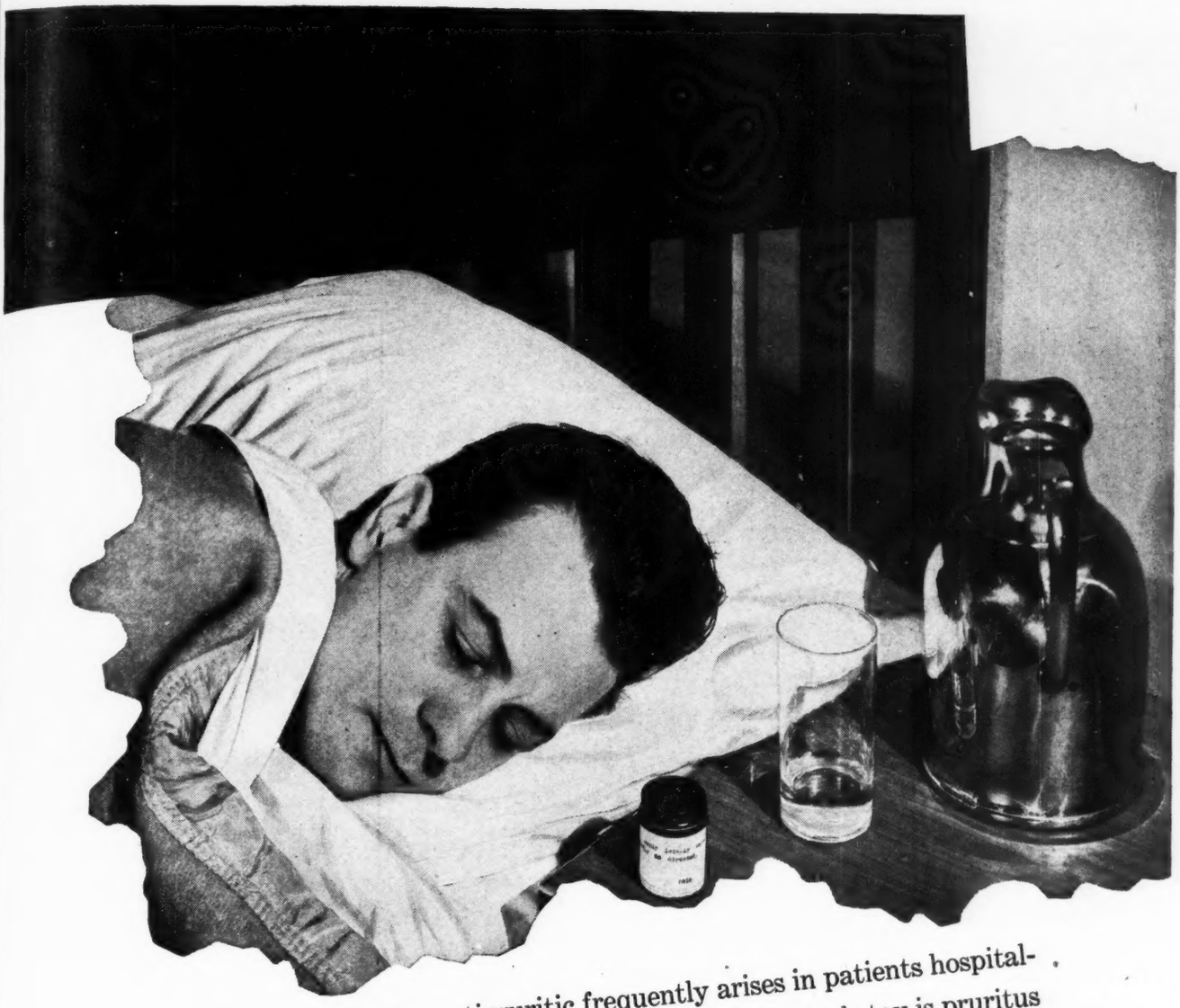
Senate Committee Favors International Health Organization

WASHINGTON, D. C.—The establishment of an international health organization came closer to realization when the Senate Committee on Education and Labor released a favorable report on Senate Joint Resolution 89 which urges the speedy convening of a conference for that purpose. The proposed health organization, endorsed by the San Francisco conference of the United Nations, would operate either as a division of the U. N. O. Economic and Security Council or as an agency closely related to the council.

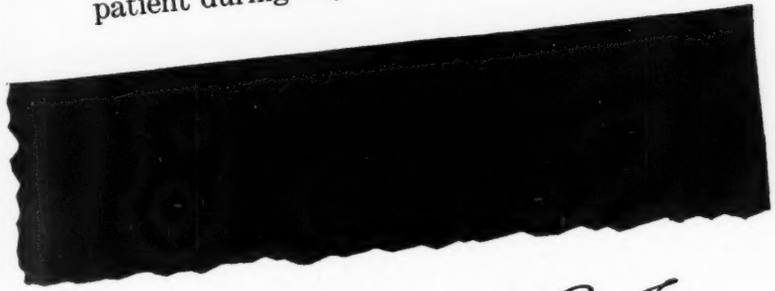
The functions of the health organization would include:

1. Collection of world-wide disease statistics.
2. Standardization and control of drugs and therapeutic agents.
3. Centralization, consolidation and subsequent distribution of health and medical knowledge.
4. Assistance to national health services in controlling diseases at their sources.

The committee report emphasized that not only would the proposed organization help safeguard the United States against epidemic diseases originating elsewhere, but, by bettering health and living standards in other countries, it would give impetus to American trade.



THE need for a dependable antipruritic frequently arises in patients hospitalized for other reasons. Especially during a prolonged hospital stay is pruritus ani apt to recur. Exacerbation of chronic pruritic skin affections, or dermatitis due to "sheet burn," is not at all uncommon. Whenever itching must be controlled, regardless of cause, Calmitol enjoys a special field of usefulness. Its specific antipruritic action is dependable and prompt. A single application directly onto the involved area is effective for hours, permitting of rest and quiet for the patient during daytime hours and uninterrupted sleep at night.



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Hawley Insists on "Medically Strategic" Placing of Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—Pulling no punches in his insistence that Veterans Administration hospitals be placed in areas that are medically strategic instead of politically strategic, Maj. Gen. Paul R. Hawley in a letter to Congresswoman Edith Nourse Rogers declared that he would not experiment with the medical care of the veteran. "Either he gets the quality of medical care that he deserves, or I quit—and quit at once," said General Hawley.

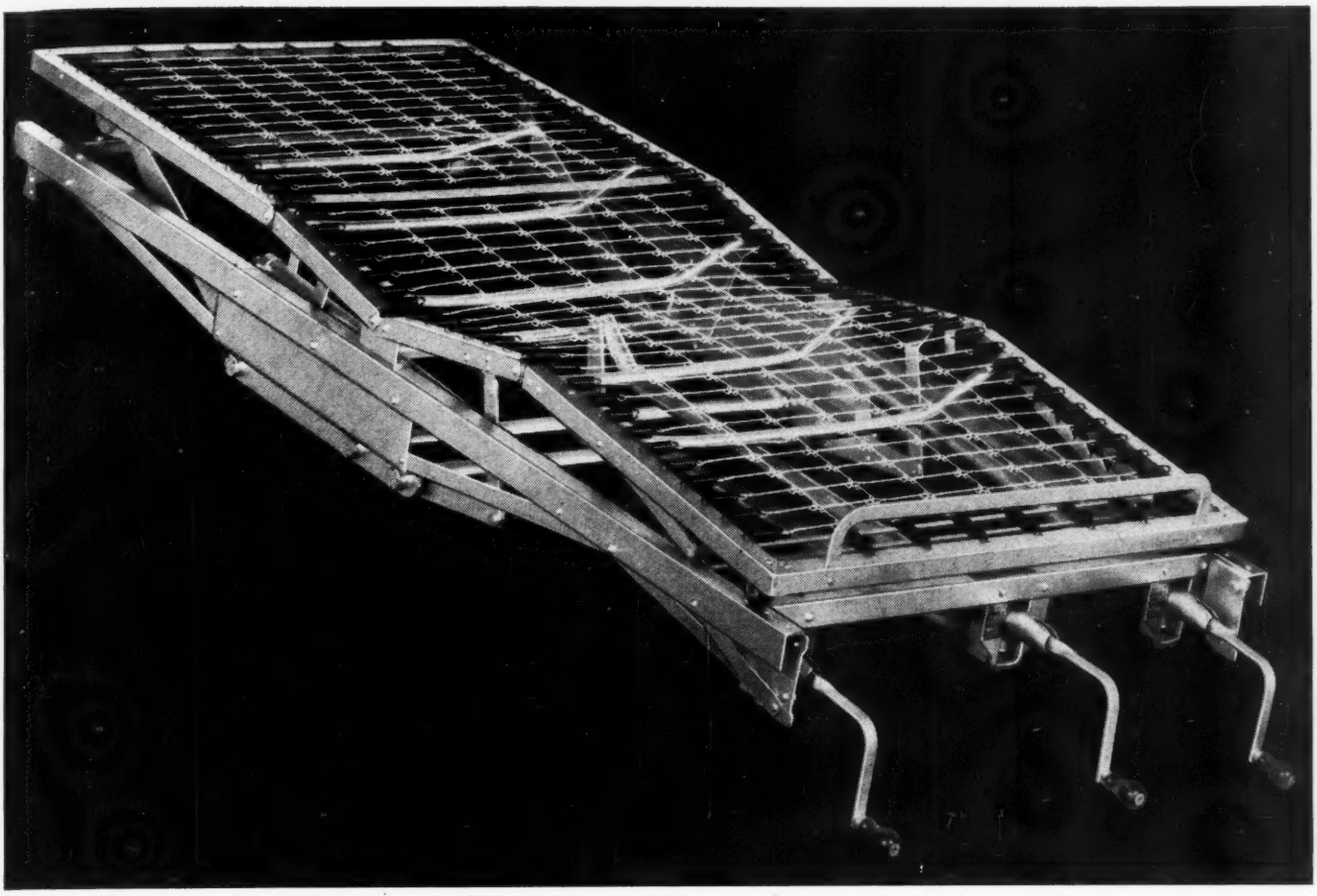
Gen. Omar Bradley and Maj. Gen. Hawley are fighting against pork-barrel politics in the placing of veterans' hospitals. They insist that as many as possible of these hospitals should be located in urban areas where medical schools and medical centers are in operation. "In such places," General Hawley said, "we can exploit on a part-time basis the huge reservoirs of medical talent in the United States. These fine specialists will not even consider coming into the Veterans Administration on a full-time basis," he continued, "but they will give liberally of part-time service *if only we take the veteran to them.*"

In explaining the crucial need of the Veterans Administration for doctors, at least 2000 of whom must be trained and qualified specialists, General Hawley asserted that at the present time 3456 doctors are required to operate the 71,284 beds now in existence. There are only 2327 doctors in the organization to fill that requirement. Almost 75 per cent of this number are medical officers of the Army or Navy lent for duty.

Unless new doctors are obtained from the outside, after the separation of most of these medical officers from the service, there will be only about 960 doctors left to fill the 3456 vacancies that exist today, and the probable 4000 vacancies that will exist by June 30, General Hawley pointed out. To staff the requisite number of beds in Army general hospitals, 2000 additional doctors would be required and it would be necessary to recruit 4500 doctors in the next six months to staff V.A. hospitals.

Plan Gives $1 Per Day Extra

An additional payment of a dollar a day to member hospitals for care of newborn babies whose mothers are eligible for maternity care benefits was announced January 2 by the Hospital Service Plan of New Jersey. Subscribers will also benefit from the increased payments, J. Albert Durgom, executive director, explained, as subscriber allowances on the hospital bill will be increased.



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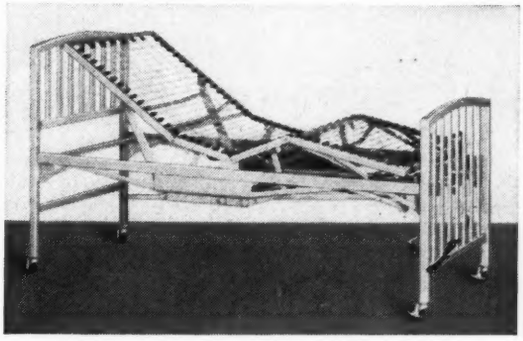

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Truman Signs Bill Establishing V. A. Medicine and Surgery Department

By EVA ADAMS CROSS

WASHINGTON, D. C.—Over-riding vigorous opposition from the civil service commission, the budget bureau, the American Legion and other veterans' organizations, President Truman on January 3 signed the bill establishing a separate department of medicine and surgery in the Veterans Administration. Opposition developed mainly from the fact that the bill includes no provisions for favoring veterans in job appointments and permits hiring and discharging of personnel without civil service approval.

The new act creates a department of medicine and surgery under a chief medical director, bringing professional personnel into an organization comparable with the Army and Navy Medical Corps and the U. S. Public Health Service. Other divisions established by the act, in addition to the Office of Chief Medical Director, are the medical service, dental service, nursing service and an auxiliary service.

Other major provisions of the new law are the following: specialists certified by the Veterans Administration will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year; residencies will be set up in veterans' hospitals where younger doctors may study to qualify as specialists; promotions will be made on recommendations of special V.A. boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers; the Veterans Administration will have complete supervision of its own professional employes, based upon their professional competence.

Under the new law 5 per cent of the V.A. medical personnel will be allowed to study or do research work for periods up to ninety days. This will enable doctors, dentists, nurses and technicians to attend recognized schools or work with the U. S. Public Health Service or other research groups.

Gen. Omar N. Bradley, Administrator of Veterans' Affairs, will establish the regulations which will replace the Civil Service rules formerly governing V.A. professional personnel. Doctors, dentists, nurses and technicians now employed by V.A. will be continued in their present jobs pending determination of their qualifications for appointment in the new medical department.

In order to overcome the acute personnel shortage, Maj. Gen. Paul R. Hawley, who is expected to become chief medical director, will need additional professional workers. Approximately 1125 doctors, 1200 nurses and 100 dentists are needed to fill the vacancies that exist at present.

Special Training Given Under Bolton Act

WASHINGTON, D. C.—As of October 15, approximately 15,000 graduate nurses have received federal aid for specialized training under the Bolton Nurse Training Act, the Division of Nurse Education, U.S.P.H.S., announced recently. Since many of these nurses could not be spared from their positions to take postgraduate preparation, a series of on-the-job courses was brought to the hospitals as an emergency measure to aid nurses pressed into positions for which they were not fully prepared. Of the 15,000, about 5000 were enrolled in these intensive courses.

In accordance with instructions of the President and Congress, Dr. Thomas Parran set October 15, 1945, as the final date on which federal funds would be available to graduate nurses for advanced study.

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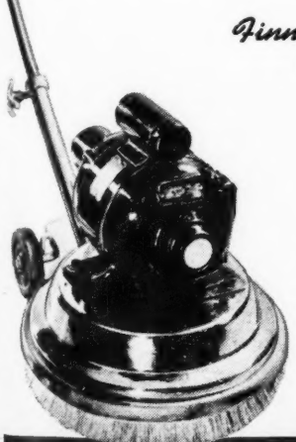

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Dean Explains Procedure for Obtaining Reduced Prices on Surplus Property

The temporary procedure established early in December to start the flow of surplus property to eligible nonprofit institutions under Surplus Property Administration Regulation 14 will shortly be replaced by a new permanent policy, Senior Surgeon J. O. Dean, chief of the Office of Surplus Property Utilization of the U. S. Public Health Service, told The MODERN HOSPITAL December 28.

Under the interim procedure, eligible nonprofit institutions are applying directly to disposal agencies for purchase of surplus property at reduced prices, instead of first obtaining approval for price preference from the U. S. Public Health Service, as provided in the original regulation. It is expected that the new procedure will establish criteria of need and use by which purchasers must qualify for eligibility to get the reduced price.

Asked how hospitals could make certain they were informed about the surplus property that is available for purchase, Doctor Dean said, "In practice, hospital people will be concerned mainly with the types of property distributed by the Reconstruction Finance Corporation. Interested institutions should request the nearest office of that agency for regular mailings on listings of available hospital equipment and supplies." A directory of R.F.C. offices is included in S.P.A. Regulation 1, Order 2.

Surplus property having no commercial value or no prospect of sale, or property of such value that the estimated cost of its care, handling and disposition would exceed the estimated proceeds of its sale, may be offered by disposal agencies for donation, Doctor Dean stated. Those eligible to receive such donations, it was explained, are (1) agencies or institutions supported by the federal government, (2) agencies or institutions supported by any state or local government and (3) nonprofit educational or charitable institutions. By earlier definition, the last named classification has been recognized as including most nonprofit hospitals.

Information about properties offered under this provision of the regulations must be obtained from the Surplus Property Administration offices. A list of these offices appears in the 1945 *Hospital Purchasing File*.

War Department Studies Release of M.D.'s, Dentists

WASHINGTON, D. C.—Personal representatives of the Secretary of War left Washington in December to make an exhaustive study of the release of doctors and dentists from the Army. A similar investigation has just been completed in the Pacific. They will determine the medical and dental strength now necessary for each overseas theater so that all surplus professional officers can be immediately shipped out for release or to replace doctors eligible for release. Radio directives have been issued for the return of surplus personnel. Highest transportation priority will be arranged to speed doctors home.

The representatives of the Secretary of War will investigate any undue delay in returning doctors who have been declared surplus. They will also determine the number of hospital beds needed to meet present conditions in the European theaters with the idea of releasing unnecessary beds.

An investigation is likewise planned in this country of Service Forces, Ground Forces and Air Forces installations to make sure that medical and dental staffs are cut as rapidly as their work loads permit. They will see that the discharge criteria are kept adjusted so that those doctors who are actually surplus will be released at once.

Hamilton Outlines Need for Fuller Hospital Service

Community surveys, hospital building and equipment consultation and advice on organization, medical and nursing staff relations, public relations, personnel, budgeting, accounting and executive controls are the services offered to hospitals by the new hospital consulting firm of James A. Hamilton and Associates, which started business in New Haven, Conn., January 1.

Associated with Mr. Hamilton, who was director of the New Haven Hospital until he resigned to enter the consulting field, are Harley A. Haynes, M.D., recently retired as director of the University Hospital at Ann Arbor, Mich.; Donald C. Smelzer, M.D., managing director of the Germantown Dispensary and Hospital, Philadelphia; John R. Mannix, director of Plan for Hospital Care, Chicago, and Oliver G. Pratt, executive director of the Rhode Island Hospital, Providence.

"Never in the history of hospitals have so many communities discovered the need for fuller hospital services," said an announcement from the new firm. "Expansion of existing facilities or the addition of new ones is general, not only throughout the United States but also in South America. At the same time that voluntary hospitals are facing a tremendous boom, government hospitals of this and other nations, already crowded with casualties and looking ahead to increasing veteran care for years to come, are also growing."

Mr. Hamilton, who has been a member of the editorial board of The Modern Hospital for several years, will continue as a lecturer on hospital administration at Yale University, where he holds the rank of professor. Among the first contracts undertaken by the new firm is consultation in connection with the $5,000,000 building project of the Grace-New Haven Community Hospital.

COMING MEETINGS

AMERICAN COLLEGE OF SURGEONS, Regional Meetings: Hotel Radisson, Minneapolis, Jan. 28-29; Hotel Jefferson, St. Louis, Jan. 31-Feb. 1; Hotel Tutwiler, Birmingham, Ala., Feb. 8-9; Hotel William Penn, Pittsburgh, March 11-12; Hotel Copley-Plaza, Boston, March 18-19; Mount Royal Hotel, Montreal, March 22-23; Hotel Statler, Detroit, March 26-27; Utah Hotel, Salt Lake City, April 8-9; Hotel Multnomah, Portland, April 12-13; Biltmore Hotel, Los Angeles, April 17-18.

AMERICAN HOSPITAL ASSOCIATION, Midwinter Conference, Drake Hotel, Chicago, Feb. 8-9.

ARKANSAS HOSPITAL ASSOCIATION, Hotel Albert Pike, Little Rock, May 17-18.

ASSOCIATION OF CALIFORNIA HOSPITALS, San Francisco, April.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Greenville, S. C., May 22-23.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Hotel Bellevue Stratford, Philadelphia, April 24-26.

ILLINOIS HOSPITAL ASSOCIATION, Abraham Lincoln Hotel, Springfield, Jan. 24-26.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 15-17.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Brown, Louisville, April.

LOUISIANA HOSPITAL ASSOCIATION, Hotel Washington-Youree, Shreveport, March 22.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, April 24-26.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 5-7.

NATIONAL CONFERENCE OF SOCIAL WORKERS, Buffalo, N. Y., May 19-25.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Atlantic City, May 21-23.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 11-13.

NEW YORK STATE HOSPITAL ASSOCIATION, New York City, June 10-12.

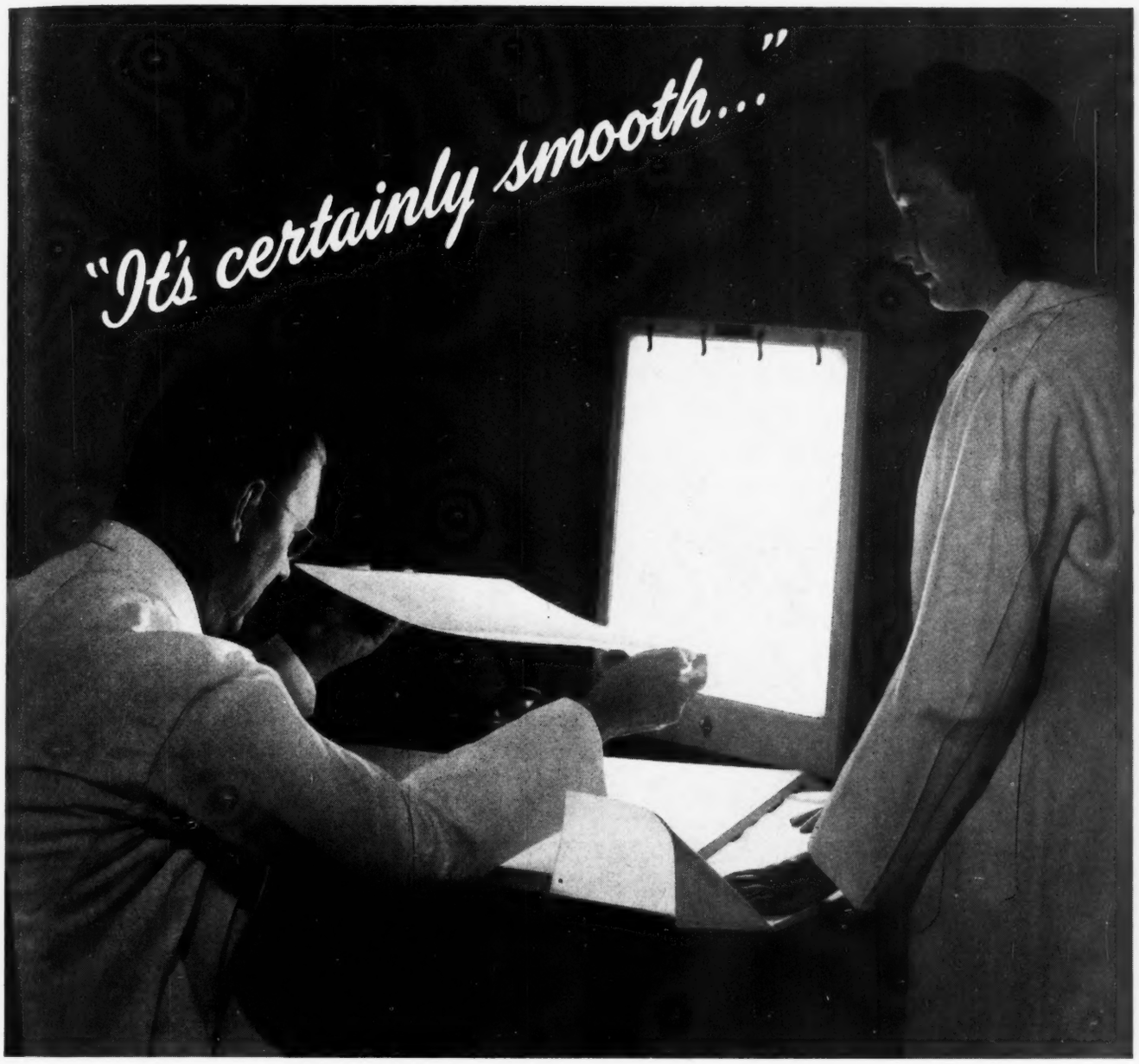
NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.

OHIO HOSPITAL ASSOCIATION, Hotel Deshler-Wallick, Columbus, April 2-4.

TEXAS HOSPITAL ASSOCIATION, Hotel Texas, Fort Worth, March 21-23.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, Feb. 14-15.



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Navy Outlines Plan of Specialist Training for Medical Officers

WASHINGTON, D. C.—Ranking civilian members of the medical profession have actively cooperated as a board of honorary consultants to the Navy Medical Department in formulating plans for the establishment of a program of specialization training, V/A. Ross T. McIntire of the Navy's Bureau of Medicine and Surgery has announced. The long-term program of specialization training to be made available to medical officers will be comparable to the best obtainable in civil life. All of the recognized specialties will be taught. Nine large naval hospitals have been designated as special centers of instruction.

Present plans call for a definite period of training for the young doctor who enters the Navy upon his graduation from medical school. This period would cover one year's internship, one or more years of residency training, two years of sea or foreign shore duty and, finally, a definite period of intensive work in this country in the field of medicine which the officer has chosen and which has been approved. Training will not be given to officers who do not wish to specialize or who demonstrate that they are better fitted for general practice.

Internships and residency training will continue to be given at all properly accredited naval hospitals, with the more advanced teaching being offered at the nine specialization centers. The postgraduate facilities of a number of civilian teaching institutions will also be used to augment the latter.

The board of honorary consultants to the Navy Medical Department are: Dr. Donald C. Balfour, director of the Mayo Foundation and Clinic; Dr. Richard B. Cattell, chief of the surgical section, Lahey Clinic, Boston; Dr. Edwin J. Cohn, department of physical chemistry, Harvard Medical School; Dr. Frank P. Corrigan, American Ambassador to Venezuela; Dr. Walter E. Dandy, professor of neurosurgery, Johns Hopkins University Hospital; Dr. Frank H. Lahey, director of the Lahey Clinic; Dr. Oswald S. Lowsley, director of the department of urology, James Buchanan Brady Foundation, New York City; Dr. James E. Paullin, professor of clinical medicine, Emory University, Atlanta; Dr. W. Calhoun Stirling, urologist, Washington, D. C.; Dr. Edward A. Strecker, professor of psychiatry, University of Pennsylvania School of Medicine, Philadelphia; Dr. Meyer Wiener, professor of ophthalmology, Washington University, St. Louis.

Veterans Administration Seeks Additional Beds

WASHINGTON, D. C.—In answer to the Veterans Administration appeal to Army, Navy and civilian hospitals for 40,000 more hospital beds, as well as additional personnel to treat veterans, the Navy Department has agreed to make available 9375 beds, Maj. Gen. Paul R. Hawley announced December 27.

Arrangements are under way with the War Department for 10,000 beds and top priority has been promised V.A. by the American Hospital Association for 20,000 beds in civilian hospitals throughout the country.

The number of veterans now receiving treatment is at an all-time peak of approximately 88,000.

Rosin Given Remington Medal

WASHINGTON, D. C.—Joseph L. Rosin, pharmaceutical chemist of Plainfield, N. J., has been awarded the 1945 Remington Medal, highest award in pharmacy, according to an announcement of the American Pharmaceutical Association. Mr. Rosin was honored as the twenty-fourth Remington Medalist for many contributions to scientific pharmacy and the development of drug standards.

International College of Surgeons Opposes Truman Health Plan

By EVA ADAMS CROSS

WASHINGTON, D. C.—More than 1000 surgeons attended the tenth national assembly in Washington of the United States Chapter of the International College of Surgeons. Doctors from Peru and the Philippine Islands and a woman surgeon from China were among those in attendance as were Dr. Desiderio Roman, president of the international organization, and Dr. Max Thorek.

Although the surgeons gave consideration to many modern surgical problems, including war surgery, they took time out to express unanimous oppositions to President Truman's compulsory national health program. A 15 point resolution adopted by the organization's board of regents was sent to the President, to members of Congress and to members of the state legislatures.

The experience of the voluntary hospital insurance plans has encouraged organized medicine in this country to sponsor a similar nonprofit program on a voluntary insurance basis to provide for payment of physicians' services, said the resolution in part. Such programs have already been placed in operation by organized medicine in more than 22 states and the launching of similar plans is imminent in other states. In commenting on the success of the voluntary hospital insurance plans, the resolution pointed out that 17,000,000 people throughout the country have been enrolled for protection against the cost of hospital services.

A. C. S. Issues List of Approved Programs of Graduate Training

A 424 page directory listing and describing approved programs of graduate training in surgery has been published by the American College of Surgeons as an aid to medical officers returning from war duty. The approved programs are available in 240 civilian hospitals in the United States and Canada and in 32 Naval, seven Veterans Administration and 10 United States Public Health Service hospitals.

Although 2000 surgeons may be trained in 750 plans offered in the 289 hospitals, training facilities for 5000 are needed for returning medical veterans whose training in surgery was interrupted by military service, the college points out. Publication of the directory, according to Dr. Irvin Abell, chairman of the board of regents, is expected to stimulate the formation of additional programs of training in suitable hospitals.

The approved programs of graduate training in surgery in civilian hospitals are located in the following states and provinces: Alabama, 3; California, 12; Colorado, 1; Connecticut, 2; District of Columbia, 5; Georgia, 3; Illinois, 16; Indiana, 4; Iowa, 1; Kansas, 1; Kentucky, 2; Louisiana, 3; Maryland, 16; Massachusetts, 13; Michigan, 16; Minnesota, 9; Missouri, 12; New Jersey, 5; New York, 40; North Carolina, 2; Ohio, 17; Oklahoma, 1; Oregon, 4; Pennsylvania, 23; South Carolina, 1; Tennessee, 4; Texas, 6; Virginia, 5; West Virginia, 1; Wisconsin, 4; Ontario, 4; Quebec, 4. Additional approved programs will be published from year to year in the Approval Number of the college *Bulletin*.

The descriptions of the approved programs include information about the size and type of hospital, organization of the medical staff, facilities for study of the basic material sciences in their application to surgery, library facilities, clinical material, manner of selecting individuals for training in surgery, scope and method of surgical training, supervision by the medical staff, examination and thesis requirements and provision for conferring higher medical degrees.

Break Down Barriers Between Voluntary and County Hospitals—Davis

The hospitals of California are organized on the wrong basis to make the greatest appeal to the generosity and support of the public, Graham L. Davis, hospital consultant of the Kellogg Foundation, Battle Creek, Mich., told a group of hospital administrators, trustees and medical staff members meeting at the Roosevelt Hotel, Hollywood. The meeting was called by the United Hospital Fund of Los Angeles County and was under the chairmanship of Ritz Hermann of the California Hospital.

The basic change in hospital organization which Mr. Davis strongly urged on the hospital leaders was to break down the barriers between the county hospitals and the voluntary hospitals to permit the former to accept pay patients and the latter to accept indigent and part-pay patients. "The voluntary hospitals of California will never have as strong an appeal to the generosity of the public as they need until they can demonstrate that they take all comers regardless of ability to pay," he said.

This does not preclude, in Mr. Davis' opinion, a proper system of payment by governmental bodies to voluntary hospitals of the major share of the cost of care of free and part-free patients.

He also urged the general hospitals to become truly general in fact. This means, he said, that they should accept patients with tuberculosis, mental disease, communicable disease and chronic conditions. They should also break down barriers based on age, sex or race.

After studying figures on the hospital situation in Los Angeles County, Mr. Davis was ready to agree with Mr. Hermann that it is probably the most seriously underhospitalized metropolitan area anywhere in the United States. Even at a ratio of 4 beds per thousand, there is a deficiency of more than 4000 general hospital beds in the county. In addition, there is a great need for additional beds for psychiatric cases, long-term illnesses and convalescent care.

The United Hospital Fund of Los Angeles is preparing to launch a $25,000,000 program to raise capital funds for the construction of needed additional general hospital facilities. Mr. Davis urged that a survey of the county be made as soon as possible so that a specific program of hospital improvement and advancement could be laid out. He indicated that it would be easier to obtain funds if it were stated exactly how many beds were to be built and the areas in which they would be constructed.

Start Construction of New Nurses' Home

Construction of a modern $90,000 home for nurses of Riverside Hospital, Toledo, Ohio, has started and is expected to be completed in May, according to Norman L. Losh, director. The three story structure will supplement the old home built more than 70 years ago and will house 32 or more staff nurses.

The new home, for which endowment gifts to the hospital are being used, will provide enlarged training facilities. A recruiting drive for new Riverside Hospital nurses will open in June, it was announced by Mr. Losh who hopes to obtain about 20 new nurses for enrollment in classes next September.

Seek $2,500,000 for Beth Israel

Beth Israel Hospital, New York City, is planning an extensive expansion program at a cost of $2,500,000. Funds will be derived largely from the current $21,000,000 drive undertaken by the Federation of Jewish Philanthropies of New York. Plans include a new dispensary, an obstetrical pavilion and a nurses' residence.

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Hospital Construction Measures Approved by President Truman

WASHINGTON, D. C.—Gen. Omar N. Bradley recently announced that President Truman had approved the following measures in the Veterans Administration hospital construction program:

1. Location of 29 new Veterans Administration hospitals in 20 states.
2. Location of a 350 bed home, including a 50 bed infirmary, at Bonham, Tex.
3. Construction of additions to existing and authorized hospitals at Peekskill, N. Y., and Columbia, S. C.
4. Transfer to the Veterans Administration of seven War Department general hospitals, five of which are designated for temporary use only.
5. Declaration of one Veterans Administration home, Camp Phillips at Salina, Kan., to be surplus.
6. Transfer of a proposed 250 bed addition originally scheduled for Excelsior Springs, Mo., to Kansas City, Mo.
7. Revision of a prior authorization for a 500 bed hospital in the Mississippi-Alabama area by substituting a 250 bed addition for the Alexandria, La., hospital, and leaving 250 beds unlocated.
8. Utilization of administrative space at V.A. general medical and surgical hospitals at Fort Howard, Md., and Dearborn, Mich., to provide for a total of 379 new beds. Of these, 79 will be added at Fort Howard to provide a total of 389 general medical and surgical beds there, and 300 at Dearborn, making a total of 1429 beds there.

The new construction announced covers the second segment of a second hospital construction program based on Veterans Administration hospitalization requirements up to and including June 1948. The two part second program, approved last August, involved the acquisition of a total of 32,500 beds, 29,100 of which were to be obtained through new construction or by transfer of available and acceptable Army and Navy hospitals.

Masonic Hospital Expands

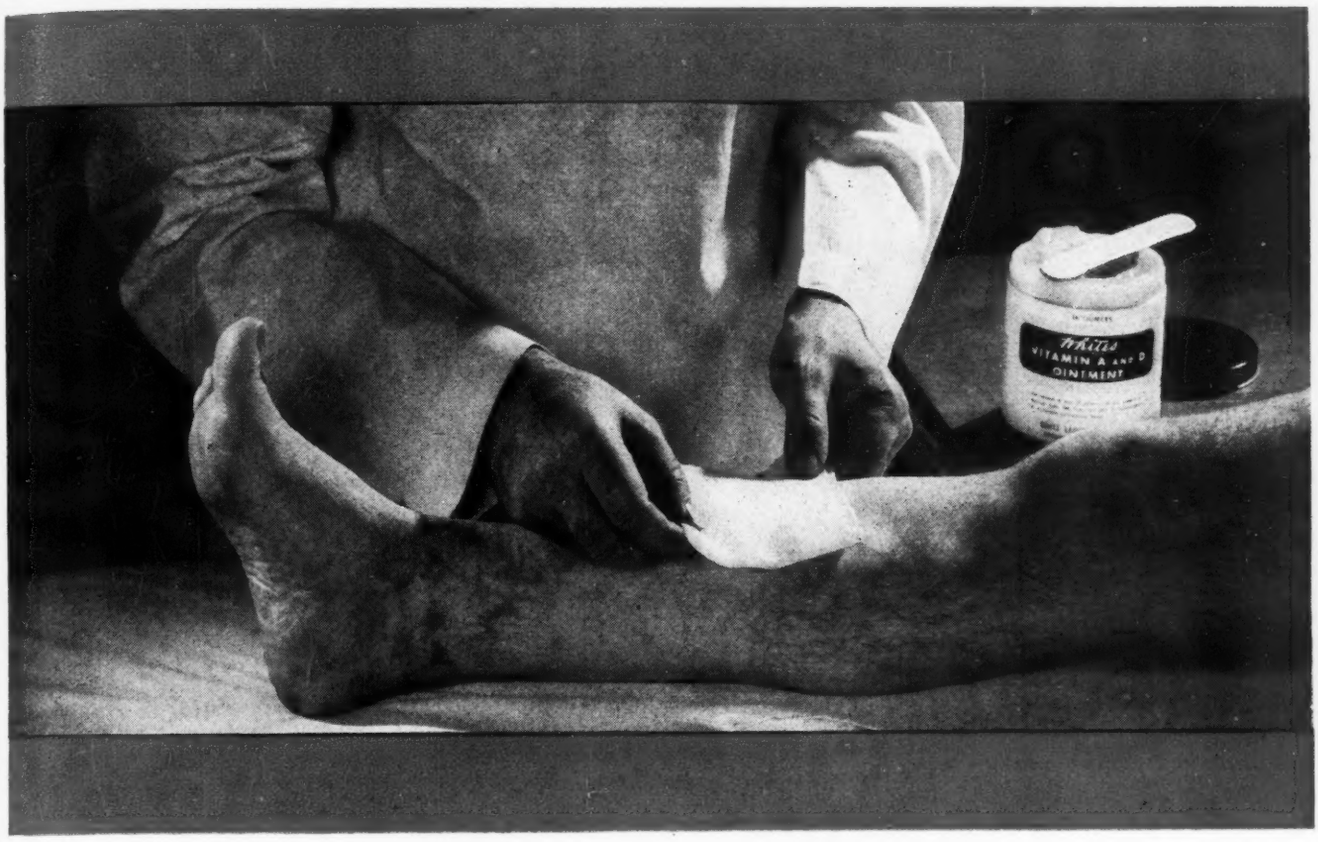
The first step in a $750,000 construction and improvement program for Illinois Masonic Hospital, Chicago, was taken January 2 when a $50,000 expansion of the laundry and boiler room was undertaken. These additions to the service plant are designed to accommodate a proposed new wing which will double the hospital's present bed capacity of 175. Construction of the new wing will be launched as soon as the present project is completed, William H. Tenney, superintendent, announced. The hospital recently completed a $150,000 nurses' home. Architects for the present expansion project are Schmidt, Garden and Erikson.

Urges State Operated Health Insurance Plan

"Decent medical care cannot be made available to all families except by compulsory payment which averages the risk," William T. Sweigart, executive secretary to Governor Earl Warren of California, told members of a state legislative committee during a hearing held recently.

As proof that voluntary measures fall short of providing necessary care, Sweigart cited the fact that California Physicians Service, the prepayment plan sponsored by the state medical association, had enrolled only 100,000 members in six years of operation. He advocated a proposed state-operated medical insurance plan as the only alternative to a centralized federal plan.

Medical society officers assured the governor's representative and members of the committee that plans were under way to improve and extend the voluntary program now in operation. They opposed any program to distribute medical care through state agencies.



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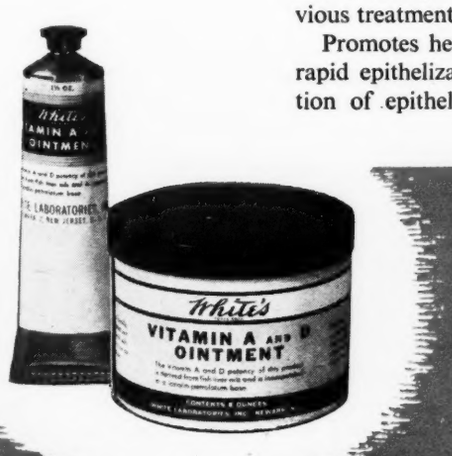

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Negro Leaders Oppose V.A. Hospital

Plans to locate a Veterans Administration hospital for Negro patients in Mound Bayou, an all-Negro community in Mississippi, are meeting with opposition from Negro groups in several Northern cities, according to a report from Benjamin A. Green, mayor of Mound Bayou. Opposition is based on objection to the principle of racial segregation in any form as a violation of American democratic ideals, the mayor said.

"Up to a certain point I can sympathize with this point of view," said Green, "but there is a time to talk theory and a time to be practical. In this section we are trying to get something that will benefit our own people right now—not a hundred years from now. Everything that advances Mound Bayou also advances the status of the Negro people everywhere in the United States. This is a quiet, peaceful, progressive community and the boys would be happier here than elsewhere."

A 53 bed hospital operated by the Sons and Daughters of Tabor, a Negro organization, was opened in Mound Bayou a few years ago.

Although segregation in Southern veterans' hospitals has been under fire by Negro leaders, Gen. Omar N. Bradley has stood by his statement of policy that local conditions must prevail. The Veterans Administration cannot be made an agency for social change and it must follow local customs, General Bradley maintains. As local custom changes, segregation will be eliminated.

A recent survey of Negro hospital facilities indicates that 17 of Veterans Administration hospitals accept no Negros except in emergency; 24 have separate wards for Negroes; one, at Tuskegee, Ala., accepts only Negroes; the 55 remaining hospitals make no distinction.

New Zealand Hospital Costs Up

Costs of operating New Zealand hospitals have quadrupled during the five years that a government medical care hospitalization plan has been in effect there, according to a report from Quentin Pope, Chicago *Tribune* correspondent in Wellington. As a result, the tax system designed to support the plan has broken down and some counties have refused to pay the increased local share of hospital costs, the report says. In retaliation against one county that has been on such a tax strike, the labor government is seeking to pass a law compelling local officials to collect hospital taxes.

Blue Cross Ends Year With Estimated Total of 20,000,000 Members

Blue Cross plans finished 1945 with an approximate total of 20,000,000 members, according to a nonofficial estimate of the Hospital Service Plan Commission office. This represents a net gain for the year of about three and one half million members, it is estimated.

Membership figures at the present time are not precise because of two factors, the commission office explained. The automobile workers' strike has affected the membership of a number of large plans—chiefly, of course, Michigan Hospital Service. While General Motors has announced that regular plan membership payments will be advanced by the corporation for member employes who will come to the plant and make arrangements for such continuation, it is impossible yet to tell what proportion of the members on strike will take advantage of this continuation feature.

Since these memberships were paid in advance at the time the strike started, the number of cancellations that will be caused by the strike is just beginning to become known, the commission office explained.

Another factor making year-end membership reports uncertain is the rapid growth during the final months of the year of several large plans—notably, Associated Hospital Service of New York and the Massachusetts plan. However, the commission office reports that the total of 20,000,000 members is a conservative estimate.

The impending strikes of steel and packing house workers will not affect Blue Cross membership or operation as drastically as the automobile workers' strike has, it was indicated, since enrollments among the steel and packing industries have not been as large in these groups.

Residents of 20 states may now enjoy protection against both medical and hospitalization expense through medical or surgical service plans sponsored by local or state medical societies and operated in connection with Blue Cross, the Hospital Service Commission office stated.

A total of 31 medical service plans is now in operation in the United States, it was reported, and two more are now operating in Canada. This represents a 100 per cent increase over the number of plans in operation a year ago, it was explained. Latest plans to start operations are those in Alabama, Ohio and Virginia, with the group in Kansas expecting to start offering memberships early this year.

National Blue Cross Opens Branch Office

The National Blue Cross enrollment office, established in New York City in July under the direction of Frank Van Dyk, has opened a midwestern branch in Chicago. Victor H. Breitenbach, formerly associated with Blue Cross plans in Kansas, Wisconsin and Chicago, is in charge of the new office, which is located at 11 South La Salle Street in the same building with Plan for Hospital Care, Chicago.

The midwestern branch will facilitate necessary contacts with corporations, labor unions and other organizations operated in a number of locations throughout the nation, the officials of the Hospital Service Plan Commission believe.

Grants for Cancer Study

Eight federal grants-in-aid totaling $42,040 to further the study of cancer have been recommended by the National Advisory Cancer Council, according to Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service. Grants of $10,000 each, the two largest, will be given to Washington University, St. Louis, and to Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City.

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Chicago "Sun" to Sell Hospital Insurance to Home Subscribers

A dollar a month hospitalization and surgical expense insurance policy was offered home delivery subscribers to the Chicago *Sun* beginning January 6. Underwritten by the National Casualty Company of Detroit, the policy offers a standard schedule of cash indemnities; $5 a day for hospital room up to twenty-one days a year, extra service charges up to $25 and, finally, surgical benefits up to $50.

Sickness benefits begin 30 days after the effective date of the policy; accident benefits are effective immediately. Maternity benefits and payments for tonsillectomy and female disorders are not available until the policy has been in force ten months.

A separate application and policy must be written for every member of the family for whom protection is desired. Only persons from 2 to 55 years old may participate. An application form is printed in the newspaper, including a statement about the applicant's medical history. No medical examination, however, is required.

Sun promotion featured the hospitalization insurance as the first offer of its kind ever made by a newspaper. "Some of the country's outstanding organizations have a hospitalization insurance plan for their employes and members of their families," the *Sun* ads said, "and such fortunate persons have become the envy of others who cannot take advantage of such a policy. The Chicago *Sun* feels that everyone should have this form of insurance protection and for that reason has made it possible for its readers to share in this plan."

After the initial payment, including a $1 registration fee in addition to the first month's premium, payments are collected monthly by the newspaper's carriers.

Hospital to Be Memorial

Ground is being purchased for a $5,000,000 memorial hospital to commemorate Southern Californians killed in World War II, Willard W. Keith, temporary chairman of the board of directors, Los Angeles, has announced. The hospital will provide beds for from 735 to 1000 patients and will occupy 15 buildings in a 25 acre tract in West Los Angeles. The institution will include units for almost all types of diseases, research, medical instruction and modern clinical service.

Among the directors are movie producers David Selznick and Walter Wanger and actor Jean Hersholt.

900 Health Jobs Vacant, Parran Points Out

A recent survey conducted by the U. S. Public Health Service revealed that there were 3000 full-time medical positions in state and local health departments of which nearly 900 are now vacant, according to Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, writing in the December 22 issue of the *Journal of the American Medical Association*. Half of the vacancies are being held for individuals on leave in the military services, said Doctor Parran, and the other half are vacancies without restrictions waiting to be filled by qualified physicians.

The surgeon general pointed out that these positions call for people with special training in public health and that several schools are already sensing the increased demand for training which leads to the degree of master or doctor of public health.

Among the advantages of being a health specialist, Doctor Parran pointed out, are daily routine, security of an annual salary which, he said, compares not unfavorably with the net income of practicing physicians in most communities, promotions, retirement plans and lack of expense of maintaining an office and equipment and employing a nurse or assistant.

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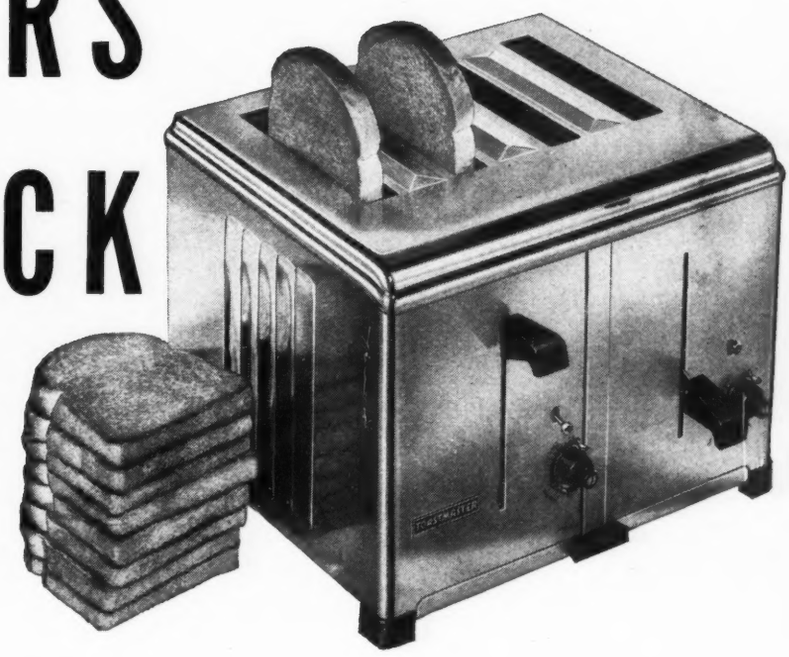

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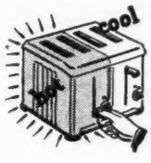

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House Committee Okays Hospital Center Bill With Modifications

By EVA ADAMS CROSS

WASHINGTON, D. C.—The National Hospital Center Bill, passed months ago by the Senate, was approved with certain changes by the House District Committee in December. The committee agreed on a federal advance for the development of a modern hospital center in the nation's capital but under a financial plan which differed from the original Tydings-Bilbo proposal. Federal, District and hospital leaders have been asked to redraft the bill with the new financial plan incorporated.

Under the recently developed plan, the federal government would advance the entire sum for the buying of the site, construction and equipping of the hospital center. Title would be held by the government but the management would be left to nonprofit private hospitals participating in the center. These hospitals would be required to bear the maintenance costs and to amortize the federal loan over a long period of years. Details will be worked out before the bill goes to the House for action.

Under the original plan, Emergency, Garfield, Episcopal Eye, Ear and Throat and possibly several other voluntary nonprofit hospitals in the District would be expanded and grouped together in a center which would be financed in part by federal funds. The participating hospitals would be responsible for maintaining the center.

The National Hospital Center would provide 1500 beds. It has been recommended that the project be estimated at not less than $18,000,000. This figure would cover hospital buildings, equipment, nurses' home and other facilities and the land.

Pink Health Plan Endorsed

A resolution endorsing the 15 point program for the establishment of health centers throughout New York State as proposed by Louis H. Pink, president of Associated Hospital Service of New York, was passed by the Greater New York Hospital Association. The association, which comprises representatives of 150 New York hospitals, described the plan as "a constructive step toward the solution of the complex problem of making better health available to everyone" and feels that Mr. Pink "has shown how new frontiers can be opened up in the field of health under the existing pattern of legislation for the greatest good to the greatest number of individuals."

Hospitalized Vets to Be Given Job Guidance and Training

In a move to expand the advisement and guidance service of the Veterans Administration, job counseling and prevocational training will be brought to the bedside of seriously disabled veterans in the 97 V.A. hospitals, according to Gen. Omar N. Bradley, Administrator of Veterans' Affairs.

Experienced counselors and advisers will go into the hospital wards to consult with veterans and assist them in planning for future employment, H. V. Stirling, assistant administrator for vocational rehabilitation and education, explained. The service will be available also to veterans undergoing treatment and planning to continue their education in colleges and universities after release from the hospital.

More than 200 regular Veterans Administration advisement centers are now in operation in colleges and universities, high schools, junior colleges and school districts throughout the country and are open to all veterans planning to pursue educational courses or on-the-job training under the Servicemen's Readjustment Act of 1944 or under Public Law 16 for disabled veterans. More than 300 of these centers will be in operation eventually, Mr. Stirling predicted.

Distinguished Doctors Named as Consultants to Vets Administration

WASHINGTON, D. C.—Brig. Gen. Elliott C. Cutler, as chief of consultants, heads a group of distinguished doctors recently appointed to serve as top consultants in medicine and surgery for hospitals, Maj. Gen. Paul R. Hawley announced in December. All consultants are World War II veterans. General Cutler is Moseley Professor of Surgery at Harvard Medical School, a member of that institution's graduate faculty and is attached to the Peter Bent Brigham Hospital, Boston.

Three of the consultants are Army men now serving in Washington. They are: Col. Roy Glenwood Spurling, Surgeon General's Office; Lt. Col. Brian B. Blades, Walter Reed General Hospital, thoracic surgery; Lt. Col. Aubrey Hampton, Walter Reed General Hospital, radiology.

Other consultants and their special fields include: Col. Barrett Brown, plastic surgery; Dr. Trygve Gundersen, ophthalmology; Dr. Bernard J. Pisani, gynecology; Dr. Donald M. Pillsbury, dermatology and syphilology; Dr. John N. Robinson, urology; Dr. Ralph Tovell, anesthesiology; Dr. Robert M. Zollinger, general surgery.

Columbia-Presbyterian Building Program Starts

The first step in the postwar building and development program for Columbia-Presbyterian Medical Center has started with the laying of the cornerstone of the additions to Maxwell Hall, residence of the school of nursing. The completion of these two 10 story wings will free vitally needed space in the hospital for additional patient beds.

Another step in the medical center's building program will be the erection of an 11 story personnel building.

The building will be called the Edward S. Harkness Memorial Hall and is a joint memorial given by Mrs. Edward S. Harkness and the trustees of the Presbyterian Hospital to the memory of Mr. Harkness.

The new building will contain furnished apartments for 200 persons. The plans call for three types of apartments: one room—living room, bath and kitchenette; two room—living room, bedroom, bath and kitchenette, and three room—with two bedrooms, a living room, bath and kitchenette. To provide all-weather access, the building will be connected by a tunnel with the hospitals.

The Edward S. Harkness Memorial Hall was designed by Voorhees, Walker, Foley and Smith and is being built by Vermilya-Brown Company.

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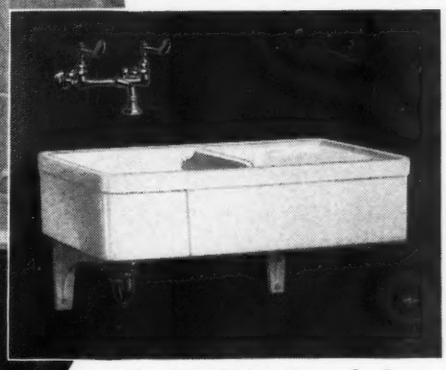

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Only One Out of Six Army Nurses to Return to Former Positions

Questionnaires returned by 31,000 members of the Army Nurse Corps and tabulated by the American Red Cross show that only one Army nurse in six expects to return to her prewar position, according to a report in the *American Journal of Nursing* for December. Though 69 per cent plan to remain active in nursing, their interests cover a wide range.

In view of the fact that 64 per cent of Army nurses came from institutional nursing, a challenging comparison is offered by a bloc of 39.5 per cent, 35.5 per cent of which displays an interest in hospital nursing and 4 per cent in teaching. In round figures, this means that five out of eight Army nurses who left institutional nursing intend to return to it, but three do not.

Entitled to educational benefits under the G.I. Bill of Rights like other veterans, additional education appeals to nearly half of the Army nurses. Among those wanting to further their education, hospital nursing, with 19 per cent, ranked first in interest, and public health nursing, with 11 per cent, ranked second. When released from the Army, 17 per cent would like to serve with the Veterans Administration and 16 per cent prefer to remain in the Army Nurse Corps.

Young nurses predominate in the Army Nurse Corps with 60 per cent of the replies being from nurses of less than 30 years of age. Civilian nurses, in contrast to Army nurses, are an older group. A survey of 5000 as reported in the same issue of the *Journal* showed that 62 per cent were over 30 years of age and 3 per cent over 60.

In the civilian group, 54 per cent expect to continue in present positions, 10 per cent to change positions, and 21 per cent to retire. There is as large a percentage of the nurses under 30 who expect to retire as there is of the older nurses.

Report of a similar questionnaire among Navy nurses will be released soon.

Physicians' Forum Terms A. M. A. Plan Inadequate

The Voluntary Health Insurance program formulated by the American Medical Association at the December meeting of its House of Delegates was termed inadequate and unsatisfactory in a statement issued by the Physicians' Forum and reported in Science News Letter.

Pointing out that lower income groups have more sickness than those in the higher brackets and at the same time have much less money to spend for medical care, Dr. Ernst Boas, chairman of the Physicians' Forum, said:

"It is obvious that voluntary health insurance as proposed by the American Medical Association will never be adequate to supply medical care to all the people. The Physicians' Forum believes that the proposal made by President Truman for nationwide social security legislation to finance health insurance in proportion to ability to pay is the only effective method."

Navy Men Win Award

WASHINGTON, D. C.—For the sixth consecutive year, the Wellcome Award went to naval personnel. The ceremonies were held at the National Naval Medical Center at Bethesda, Md. Joint recipients of the award, established by the late Sir Henry Wellcome, were Capt. Joseph S. Barr, Medical Corps, U. S. N. R.; Capt. R. H. Draeger, Medical Corps, U. S. N., and Cmdr. W. Warren Sager, Medical Corps, U. S. N. R. Their paper on "Solid Blast Personnel Injury" was selected by the Association of Military Surgeons as the best submitted in the annual competition.

Winter General to Be Neuropsychiatry Center

WASHINGTON, D. C.—Winter General Hospital at Topeka, Kan., has been acquired from the Army by the Veterans Administration to become a center for teaching neuropsychiatry to V.A. physicians. The noted psychiatrist and author, Dr. Karl A. Menninger, will head the new center.

The teaching center will train physicians to care for the increasing load of patients suffering from neuropsychiatric disabilities. The accelerated course in neuropsychiatry will give the doctors additional training in psychiatry, psychology, psychoanalytic orientations, psychosomatic medicine and other related subjects. Groups of physicians will be rotated through the course.

The hospital will split its bed capacity among neuropsychiatric, general medical and domiciliary patients.

Medical Center Comes Closer

The west side medical center, a dream of Chicago planners for a quarter of a century, came one step closer to realization with Governor Green's recent release of $641,000 to acquire west side property. The money is part of $1,100,000 designated for the center and included in the state's postwar public works program. The total area for the proposed center covers 302 acres.

Hospital Invites Negro Physician to Join Medical Staff

An invitation to the city's leading Negro physician to become a full staff member and use the hospital's facilities at any time for his patients marked the recent opening of the 80 bed Raiford Memorial Hospital at Franklin, Va. The new hospital, which was built with the assistance of F.W.A. funds under the direction of Gibson Howell, administrator, will serve a number of small communities in the Hampton Roads section.

The hospital is named for Dr. R. L. Raiford of Franklin, who founded its predecessor institution some years ago.

Commenting on the departure from established practice in most Virginia hospitals, the Norfolk *Virginian-Pilot* said in an editorial: "Illness is no respecter of color or creed. Raiford Memorial Hospital has the distinction of validating this humanitarian precept by welcoming to its staff, and to full hospital privileges, qualified Negro physicians. No other single act so happily identifies this institution as an establishment for the alleviation of human distress."

Christmas Eve Fire Probed

A Christmas Eve fire in a rest home operated for the aged, convalescent and chronic patients by Hartford, Municipal and St. Francis hospitals at Hartford, Conn., is being investigated. Thirteen patients and two attendants died in their rooms or as they were being removed to the snow-covered streets; two other patients died Christmas Day, and two aged patients were in critical condition.

Attendants had set up a Christmas tree in the office of the home to brighten the patients' lonely holiday, and a short circuit in the lights on the tree started the fire. It was reported that some rattled person may have opened a door to let zero winds sweep the flames upstairs.

Fund Drive Continued

St. Rita Hospital's building campaign for $250,000 to finance the construction of a new wing on the hospital at Lima, Ohio, will continue through February 3. J. H. Shields is general chairman of the campaign, the realization of which will increase the 101 bed capacity to 181. Mr. Shields' previously directed a successful drive for Lima Memorial Hospital.

Ontario Government Grants Will Wipe Out Hospital Deficits

A new system of hospital grants calling for additional payments of more than $1,000,000 a year by the Ontario government has been announced by Hon. Dr. R. P. Vivian, minister of health.

According to the new system, the amount of the grants is determined by application of a formula based upon several factors. Among these are the ratio of public ward beds to the total bed capacity and the percentage of public ward beds occupied during the year. For example, one of the largest Toronto hospitals has 1139 beds; 760 are public ward beds and of these, 87 per cent are occupied for every day in the year. In this instance, the grant is consequently larger than that to a hospital with a smaller percentage of public ward beds and a lower bed occupancy. The grant from the Ontario government in 1944 was $96,080 for this hospital; in 1946, under the new policy, its grant will be $285,225, or an increase of $189,145.

"What we are trying to get under this new policy," Doctor Vivian explained, "is more public ward beds at a price the average individual can afford. The new policy is to provide an arbitrary fixed amount for every public ward bed in the hospital, irrespective of whether it is occupied or not."

Hospitals, under the new system, are expected to become self-sustaining. Instead of showing annual deficits, it is explained, hospitals will be able to provide service at cost, thus benefiting patients in both public and private wards. For the public ward patient, the government policy is planned "to permit the average individual to pay for his own hospital maintenance" in that the cost of hospitalization will be kept at a reasonable level.

The new policy will protect the public against an increase in cost per bed and will permit the hospitals ultimately to reduce the cost of semiprivate and private accommodations for the private patient.

In operating the new system, hospitals are classified into certain groups giving recognition to the fact that teaching hospitals bear a heavy financial burden because of the added facilities they provide in addition to the large number of ward beds they contain.

Teaching hospitals in the three university centers of Toronto, Kingston and London are classified as Group A. Other large public general hospitals in the same centers but not used for medical teaching have been classified as Group B. In addition to Group B, there are many institutions throughout Ontario in need of additional assistance, according to Doctor Vivian, and it is planned to extend such assistance as quickly as possible.

Hawaii Association Elects New Officers

The following officers were elected at the annual meeting of the Hospital Association of Hawaii held recently at Honolulu:

President, Dr. William F. Leslie, director, Puumaile Hospital, Hilo, Hawaii; president-elect, Thelma Hensley, R. N., Samuel Mahelona Hospital, Kauai; first vice president, Rose Littell, R. N., Malulani Hospital, Wailuku, Maui; second vice president, Uichi Kanayama, Kuakini Hospital, Honolulu; third vice president, Lavelle Sinclair, R. N., Kohala County Hospital, Hawaii; secretary, Mabel. F. Johnson, R. N., Shriners' Hospital for Crippled Children, Honolulu; treasurer, Vergil F. Bradfield, Leahi Hospital, Honolulu.

Featuring the program was a panel discussion on the subject, "Is It Possible to Stabilize Nursing in Hawaii?" Part of the program was devoted to a study of tuberculosis and related subjects, and dietetic internship and record librarians provided other topics for discussion at the meeting.

Red Cross Gives Plasma for Veterans

A "bank" of 125,000 units of blood plasma, which is expected to satisfy the needs of the 97 Veterans Administration hospitals for four years, has been made available to the Veterans Administration by the American Red Cross. The allocation was made from the reserve blood plasma returned by the Army and Navy after the cessation of hostilities and thus the veterans can obtain plasma which was originally contributed for use of the services to which they belonged.

After allotments are made to V.A. hospitals for their immediate needs, the remainder will be stored in warehouses at Perry Point, Md., and Hines, Ill., from which plasma will be distributed to the hospitals as needed. At the end of the first year of plasma use, V.A. officials stated, a check will be made to see what the demand has been and to provide information for possible future requests to the Red Cross.

Make Grants to Study Cardiacs

Medical schools of six universities will receive grants totaling $126,000 from the Life Insurance Medical Research Fund to be used for research into the causes of cardiovascular diseases. Recipients, as announced by M. Albert Linton, chairman of the fund, are Columbia University, University of Minnesota, University of Pennsylvania, Southwestern Medical College at Dallas, Tex., Washington University at St. Louis and Yale University.

Wisconsin Plan Covers Workers During Job Shifts

Operating on the principle of "Once a Member, Always a Member," Wisconsin's Blue Cross plan has made provisions whereby more than 38,000 subscribers and dependents in the state, the majority of them war workers temporarily idle or in new places of employment during the past several months, have been allowed to continue their protection at no rate increase in Associated Hospital Service, Inc.

Although initial enrollment in the Blue Cross plan can be made only through a group at a place of employment with payment arranged on the payroll deduction system, nevertheless, subscribers who retire, change employment or are unemployed may continue coverage if payment is made directly to Blue Cross office headquarters in Milwaukee.

Columbia Announces Library Courses

A program of related courses on medical and hospital librarianship has been announced by the School of Library Service, Columbia University, for the 1946 summer session.

Medical Library Administration, one of the core courses, is planned to equip librarians in administering medical, nursing, pharmaceutical and dental libraries. In addition to administrative phases, emphasis will be placed also on the literature of medicine and its collateral sciences.

Another course, Library Work With Hospital Patients, will deal with the values of library work with patients, and brief attention will be given to conducting libraries for the physicians and nurses of a hospital staff.

Information regarding the courses may be obtained by writing the Dean, School of Library Service, Columbia University, New York 27, N. Y.

Robinson Heads Study

Helen Robinson, former administrator of the University of Arkansas Hospital at Little Rock, has been appointed director of study for the hospital survey board in Arkansas.

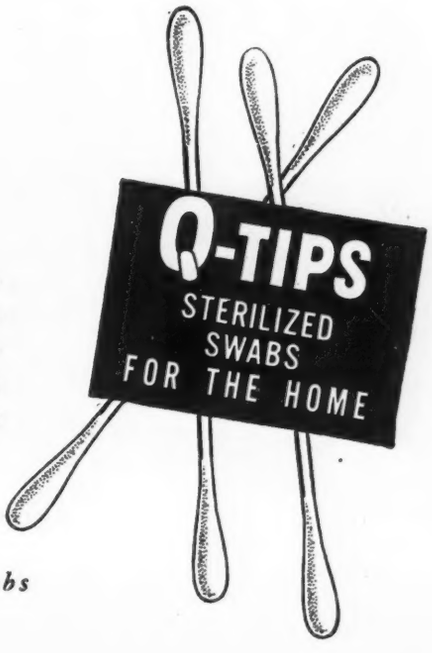
Contribution to Technique..

Ready-prepared applicator swabs, made by machine, are an important contribution to today's smoother techniques. Made *right*—uniform, firmly woven, safely anchored to the stick—they are predictable in absorption rate and performance.

Then, too, the use of ready-prepared swabs is now saving precious hours formerly spent by nurses and nurses' aides in the preparation of cotton-tipped applicators. When you are in need of regular hospital 6″ single-tipped applicator swabs, buy *ready-prepared swabs.*

For HOME USE and INFANT CARE

Recommend Q-Tips double-tipped 3″ applicator swabs. They are made with the same care and precision as hospital swabs and *steam-sterilized* in the package. Highest professional endorsement for 17 years. Sold by all drug stores—25¢ the package.



Q-TIPS, Inc., New York, N. Y.

World's Largest Manufacturers of Applicator Swabs

Hamot Hospital to Expand

A modernization program totaling $1,800,000 is under way for the Hamot Hospital, Erie, Pa. This will include a new 10 story building, modernization of existing buildings and expansion of x-ray, laboratory and auxiliary facilities, providing complete reorganization of services. Construction of the new hospital building will increase the capacity from 330 beds to 483 for adult patients plus facilities for the care of new-born babies.

The present program is the first step in a countywide plan to raise the inadequate ratio of 3.1 general hospital beds per thousand population to the minimum of 5 for each one thousand population as recommended by public health and hospital authorities.

Hospital Is Held Liable

A jury of 10 men and two women returned a verdict of guilty against the Lawrence and Memorial Associated Hospitals, Inc., New London, Conn., as the result of the tragedy at Lawrence Hospital April 1944, when five infants died after they were mistakenly fed boric acid crystals. Damages of $2250 were awarded the parents of each of the infants; they had sued for $15,000 each. Damages of $800 were awarded to the parents of a child sickened by the crystals.

The fathers of the infants were in the Navy and attached to the submarine base in New London at the time of the accident.

"Research Foundation" Started

WASHINGTON, D. C.—At a meeting in December which marked the seventy-fifth anniversary of Children's Hospital, Washington, D. C., it was announced that doctors of the hospital have started a "research foundation" to compile and publish discoveries they have made in the hospital's wards that may be helpful to all who deal with children's diseases. Dr. Joseph S. Wall, chief of staff, said it had long been felt that the results of the medical staff's study of sick children would accrue to the benefit of all who might be reached through publication of its work. Doctor Wall hopes that the doctors' discoveries will prove so valuable to the store of knowledge of pediatrics that later some endowment may be made specifically for research.

Blue Cross Is Part of Bargain

In a story published recently in the *Monthly Labor Review,* the Bureau of Labor Statistics declared that membership in Blue Cross and other hospitalization and medical insurance plans is becoming a feature of collective bargaining. Negotiation meetings between labor and management representatives today, it is explained, commonly include consideration of labor welfare problems, as well as the traditional subject of wages, hours and work conditions, and Blue Cross membership has played a prominent part in many important collective bargaining meetings during the last year.

Ask Aid for Negro Hospital

Church groups have already pledged their support, and assistance of residents and business organizations of Evanston and the North Shore is being sought in a current drive to complete the $200,000 Evanston Community Hospital, Evanston, Ill. More than $30,000 has been raised for the hospital, which is the only medical center for Negroes residing in Chicago's northern limits and suburbs.

At the time the present hospital was established in 1930, the 18 bed capacity was not considered adequate; for years, the daily average has been 28 patients. The proposed structure will accommodate 50 patients and was designed by Perkins, Wheeler and Will, Chicago architects.

ABOUT PEOPLE

(Continued From Page 92)

the last six years and a personal member of the Hospital Association of Pennsylvania since 1939.

Vernon A. Reed has been selected as superintendent of Deaconess Hospital, Buffalo, N. Y., to fill the vacancy created by the recent death of **Henry T. Brandt.**

Maj. Gale H. Rice has returned to his duties as comptroller at Nassau Hospital, Mineola, N. Y., following three years' service in the U. S. Army during which time he was with the Medical Administrative Corps. Major Rice has been associated with Nassau for 16 years.

James Moore has resigned as administrator of Norwegian-American Hospital, Chicago. He will be succeeded by **Alvin Langehaugh,** recently returned from the Army Medical Administrative Corps. Mr. Langehaugh was formerly administrator of Lutheran Hospital, Fort Dodge, Iowa.

Department Heads

Mark Berke has taken over the post of accountant of Mount Sinai Hospital, Cleveland. He was formerly associated with the Hospital for Joint Diseases, New York.

Katheryn H. Power, former advertising manager of Dresser Manufacturing Company, Bradford, Pa., has been appointed to the new post of public relations director at Shadyside Hospital, Pittsburgh.

Maj. Arthur W. Harvey has been discharged from the Army and has returned to his duties as chief pharmacist and purchasing agent at Western Pennsylvania Hospital, Pittsburgh.

Audris Rife, for eight years chief dietitian at Grace Hospital, Hutchinson, Kan., and later with the University of Kansas at Lawrence, has assumed her duties as chief dietitian at Bethany Hospital, Kansas City, Kan. She is the retiring president of the Kansas State Dietetics Association. Her assistant is **Ina Belle Zimmerman.**

Mrs. Alta M. Leonard has been named director of nursing service and the school of nursing at West Suburban Hospital, Oak Park, Ill. She has held similar posts at Silver Cross Hospital, Joliet, Ill., and at St. Luke's Hospital, Denver.

Elizabeth Hayes has been appointed director of volunteers and special services of Western Pennsylvania Hospital, Pittsburgh. Miss Hayes formerly was office manager of the institution.

Mildred C. McFerren is the new director of nursing service and of the school of nursing of Queen's Hospital, Honolulu, T. H. Miss McFerren holds the M.A. degree in nursing education and has been director of nursing at Community General Hospital, Reading, Pa., and at Sewickley Valley Hospital, Sewickley, Pa.

Warren E. Toy, graduate pharmacist and formerly in the hospital supply field, is the new head of purchasing and storeroom at Wesley Hospital, Wichita, Kan.

Trustees

Mrs. Albert Crutcher, president of the board of directors of Children's Hospital, Los Angeles, has resigned after forty years' service in that capacity. Mrs. Crutcher has been associated with the institution, the only one of its kind in Southern California, since its organization and plans to devote all of her time now to the new expansion program which includes building a new $3,000,000 hospital.

Miscellaneous

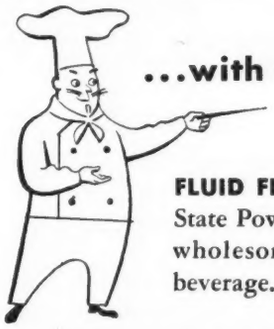
H. Elizabeth Messick, former director of occupational therapy for the District of Columbia Health Department, has been appointed director of the occupational therapy branch of the Office of the Army Surgeon General. A graduate in occupational therapy courses affiliated with the Sheppard and Enoch Pratt Hospital, Johns Hopkins University and

Your Chef likes this kind of Milk Cookery

When you see his enthusiasm, you readily can believe he'll wax poetic over the ease of preparing tasteful, nutritious milk-rich dishes with Golden State Powdered Whole Milk with full cream content.

Perhaps you'll even join his effort when your sharp pencil figures the economies this new way of milk cookery brings.

Golden State Powdered Whole Milk is fresh, whole milk with the moisture removed... not a substitute... not skimmed milk. Our cookery experts, in conjunction with practical institution chefs, have worked out efficient ways to use it—either as a DRY ingredient or RE-LIQUEFIED—to enrich many dishes, and to fortify food ordinarily milk-poor with rich milk nutrition value.



...with these advantages

FLUID FLAVOR—Re-liquefy Golden State Powdered Whole Milk. Try its wholesome, dairy-fresh taste as a beverage.

EASY STORAGE—NO REFRIGERATION—Requires little space. Keeps full food value and freshness when stored in any cool, dry place.

LIGHTENS KITCHEN LABOR—Lessens dishwashing and heavy lifting, and proves a real work-saver in many ways.

FREE Booklet for you. You'll be interested in these quantity cooking methods and recipes proved in institution kitchens. Also gives food-value tables and other details. Send for your free copy.

GOLDEN STATE SALES CORPORATION

SAN FRANCISCO, 425 Battery Street • NEW YORK, 500 Fifth Avenue • CHICAGO, 221 No. LaSalle St.
ATLANTA, 32 Peachtree Street • DALLAS, Republic Bank Building

GOLDEN STATE POWDERED WHOLE MILK

Walter Reed General Hospital, Miss Messick served as a member of the Walter Reed staff from 1933 to 1939.

Jon M. Jonkel has resigned as director of the department of public relations of the American Hospital Association in which capacity he has served for the last two years. Mr. Jonkel is establishing an organization to specialize in public relations problems confronting hospitals and will locate his offices in Chicago. Previous to his affiliation with the association, Mr. Jonkel was a public relations consultant to industry in the promotion of new products, in institutional advertising and in the development of consumer and employe attitude.

Lt. Col. Margaret D. Craighill, consultant for women's health and welfare to the Army's Surgeon General, has been named consultant for the medical care of women veterans, the first position of its kind in the Veterans Administration, according to **Gen. Omar N. Bradley,** Administrator of Veterans' Affairs. Colonel Craighill is a specialist in surgery and gynecology. Prior to joining the Army, she was dean of the Women's Medical College of Pennsylvania, Philadelphia, from which position she is now on leave.

Capt. Sue S. Dauser, N.C., U.S.N (R.), has been awarded the Distinguished Service Medal for exceptionally meritorious service as superintendent of the Navy Nurse Corps since 1939. A member of the corps since 1917, she served as chief nurse at Naval Base Hospital No. 3, Edinburgh, Scotland, in 1917 and 1918 and held the position of chief nurse in many naval medical facilities at home and abroad from that time until she took over the duties of superintendent of the corps. Captain Dauser has been succeeded as superintendent of the Navy Nurse Corps by **Cmdr. Nellie Jane DeWitt,** a member of the corps since December, 1918.

Dr. Victor Vogel, senior surgeon, U. S. Public Health Service, succeeds **Dr. Jack Masur** as chief medical officer of the Office of Vocational Rehabilitation. He has been assistant chief medical officer for more than a year. Doctor Vogel is a graduate of the University of Colorado Medical School. He holds the degree of master of public health from Johns Hopkins University. He is a diplomate of the National Board of Neurology and Psychiatry and fellow of the American Psychiatric Association. He served as assistant chief of the Mental Hygiene Division and as mental hygiene consultant to the states, U. S. Public Health Service, from 1940 to 1942.

Olin E. Oeschger of Ann Arbor, Mich., has been named director of the bureau of personnel of the Board of Hospitals and Homes of the Methodist Church and has assumed his new duties at the board's headquarters offices in Chicago, according to **Dr. Karl P. Meister,** executive secretary of the board. Mr. Oeschger has been associated with the business office staff of the University of Michigan Hospital for several years.

Ellen Morse, chief nurse of the Veterans Administration Hospital, West Roxbury, Mass., will take charge of all nursing activities for the seven Veterans Administration hospitals in branch area No. 1 with headquarters in Boston.

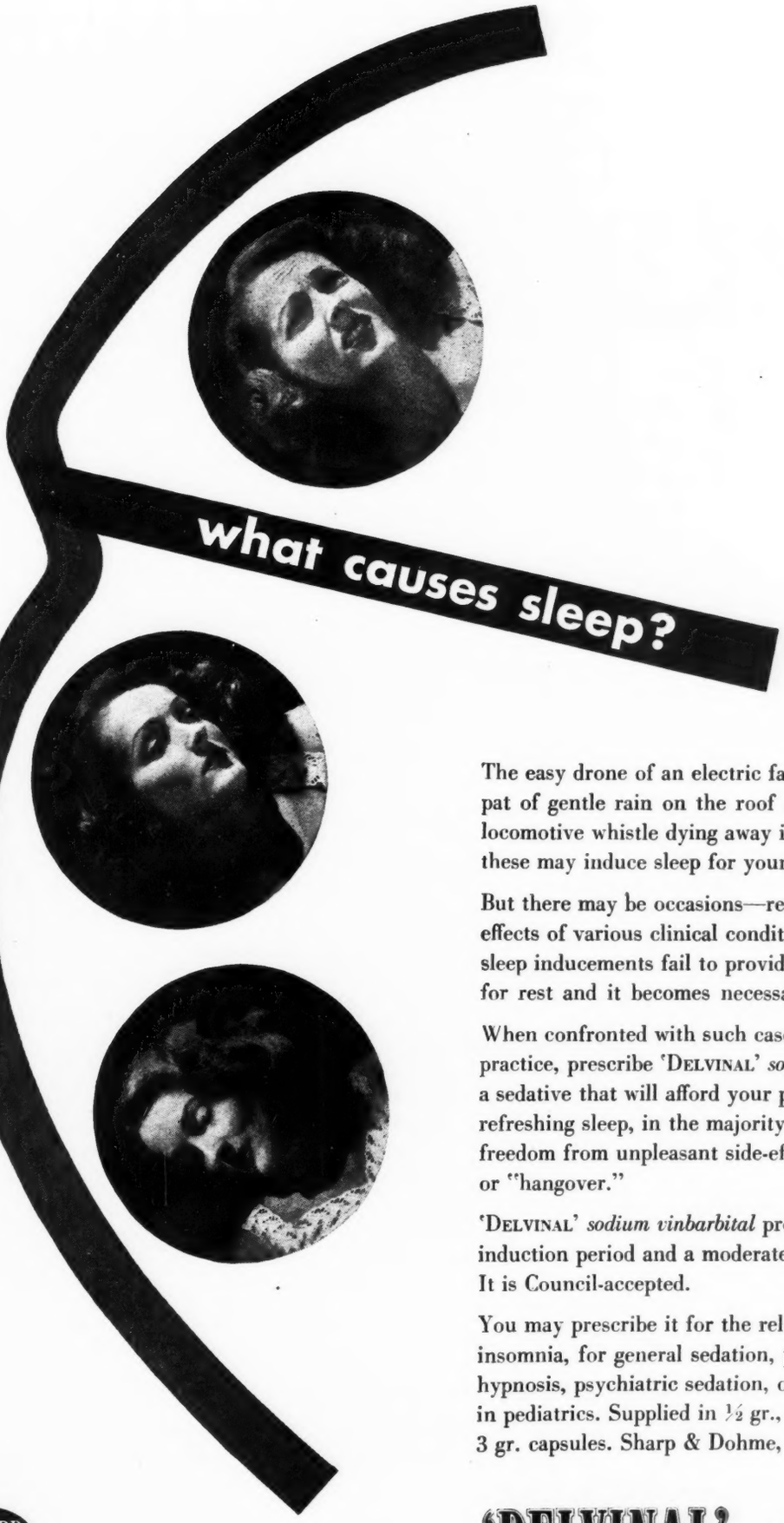
Helen G. Schwarz has resigned as assistant director in charge of the western area, Division of Nurse Education, U. S. Public Health Service, to go to Minnesota as nurse education adviser on the Minnesota State Board of Nurse Examiners.

Deaths

Dr. Leon M. Wilbor, former superintendent of San Francisco City and County Hospital and former president of the Western Hospital Association, died recently at Cathedral City, Calif.

Charles D. Bates, president of the board of trustees of Peralta Hospital, Oakland, Calif., since its inception, died December 10. **William Cavalier,** the vice president of the board, also died recently.

Dr. Joseph L. Warne, former proprietor of Lemos B. Warne Hospital, Pottsville, Pa., diēd recently.



The easy drone of an electric fan . . . the steady pat-pat of gentle rain on the roof . . . the distant sound of a locomotive whistle dying away in the night . . . any of these may induce sleep for your patients.

But there may be occasions—resulting from the effects of various clinical conditions—when ordinary sleep inducements fail to provide satisfactory conditions for rest and it becomes necessary to prescribe a sedative.

When confronted with such cases in your practice, prescribe 'DELVINAL' *sodium vinbarbital*—a sedative that will afford your patients a night's refreshing sleep, in the majority of instances, with relative freedom from unpleasant side-effects of excitation or "hangover."

'DELVINAL' *sodium vinbarbital* provides a relatively brief induction period and a moderate duration of action. It is Council-accepted.

You may prescribe it for the relief of functional insomnia, for general sedation, production of preanesthetic hypnosis, psychiatric sedation, obstetric amnesia, and in pediatrics. Supplied in ½ gr., 1½ gr., and 3 gr. capsules. Sharp & Dohme, Philadelphia 1, Pa.

SHARP & DOHME

'DELVINAL' *Sodium Vinbarbital*

OFFICIAL ORDERS
December 4 to January 4

Brushes.—All restrictions governing the manufacture of brushes made from pigs' and hogs' bristles and the sale of these brushes have been removed, the Civilian Production Administration announced December 4. The amendment of Order M-51 effected the change. It is expected that new supplies of bristles will soon be available from the formerly occupied areas in China that are the chief source of bristles.

Cabinets and Dispensers of Paper Towels and Toilet Tissue.—These are again on the market and effective December 21, retailers are allowed to increase their prices to consumers to compensate them for the higher prices permitted manufacturers.

Cotton and Rayon Fabrics.—To encourage an increase in production and to protect consumers against possible quality deterioration, the O.P.A. announced December 17 that some major changes would be made in the price order for rayon and other synthetic fabrics. On December 20 the announcement was made that about 40 minor cotton fabrics would be repriced, among them surgical dressings. Other items affected are laundry nets, huck and crash towels, combed sheets and pillow slips. In only a few cases are the retail prices to be affected.

Dairy Products.—With the exception of butter, civilians may expect to obtain about the same quantity of dairy products during the first quarter of 1946 as they did during the October-December quarter. The U. S. Department of Agriculture announced on January 4 that practically all the nation's production of butter during the January-March quarter will be for civilian use, but even so the allocation is about 30 million pounds smaller than in the previous quarter.

Price Controls.—Ceiling prices for combination storm and screen doors and window and sash screens with 14 by 18 mesh screen wire cloth were announced by the O.P.A. on December 5. A new mesh bronze wire insect screen cloth for use in window screens and screen doors was put under a ceiling price on December 15.

Separate ceiling prices for cash registers 20 years and older were eliminated as of December 3 and these machines have been moved to the higher price category of machines manufactured between 1925 and 1935.

Price control over cotton threads was suspended as of December 4; the ceiling prices on white potatoes will continue to be suspended for the period beginning December 6 and ending March 6, 1946, and, effective December 15, price control was removed from 12 miscellaneous commodities—mostly minor food items.

Sugar.—A revised sugar ration order was issued and made effective January 1. The O.P.A. has provided specialized forms for particular types of applications and it is possible for an applicant to determine his own eligibility by answering specific questions.

Directs Four Fund Drives

Hospital fund-raising campaigns totaling more than $4,000,000 are currently in progress under the direction of Ketchum, Inc., of Pittsburgh, and are expected to be completed in February. The following hospitals are participating:

McKeesport Hospital, McKeesport, Pa., which seeks to raise $400,000 for an additional wing; Morristown Memorial Hospital, Morristown, N. J., $1,250,000 for a new building; Mercy Hospital, Benton Harbor, Mich., $300,000 for a new wing, and University of Pittsburgh Medical Center, $2,500,000 for a new nurses' home and training school.

Rochester General Will Make Chest X-Ray Tests on All Patients

Rochester General Hospital, Rochester, N. Y., will provide a chest x-ray examination, without charge, for every patient admitted, in accordance with the policy recently approved by the medical board and adopted by the board of directors. Patients readmitted to the hospital will receive free routine chest x-ray examinations once every six months.

The standard 14 by 17 inch film will be used for the present and the radiologist's findings will be incorporated into the patient's medical record.

A similar service is being made available for hospital employes, including house officers and students. They will receive chest x-ray examinations without charge every six months by appointments scheduled through the employe health department.

Hospitals Receive Charters

St. Mary's Hospital, De Kalb, Ill., and St. Joseph Hospital and Mercyville Sanitarium, Aurora, Ill., were among the not-for-profit corporations to receive state charters recently to establish homes for the aged and sanitariums in addition to conducting hospital facilities.

MORE EVIDENCE why Acousti-Celotex Is Your Best Buy in Sound Conditioning!

The Superintendent of Bothwell Memorial Hospital Writes:

I have been intending for some time to write you, telling you how much we are enjoying the peace and quiet in our hospital since the installation of the Acousti-Celotex. We have had repeated comments on it from patients, doctors, and visitors as well as our own employees. More so from patients who have been here previous to its installation.

Several of the doctors have made the statement that it is one of the best improvements that has been made in the hospital since its opening.

Sincerely,

Marie Steck Superintendent
John H. Bothwell Memorial Hospital
Sedalia, Missouri

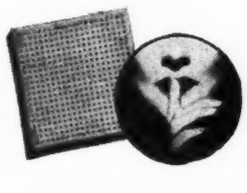
20 years of performance records like this are the reason why *more hospitals sound-condition with Acousti-Celotex than with any other acoustical material!*

Only Acousti-Celotex gives you this double advantage in assured results: 1. *Quality control in manufacture* backed by the reputation and resources of the world-famous Celotex Corporation. 2. *Quality control in installation* backed by Celotex-selected-and-trained local distributors. The experience of more than 100,000 installations makes this the leading acoustical organization in the world.

No matter what your noise reduction problem, consult your local Acousti-Celotex distributor. No obligation. No job is too small. Or write to Celotex, Dept. MH-146, Chicago 3, Illinois.

FREE! "*The Quiet Hospital*"

Timely! Interesting! Informative! For *your* FREE copy of this fact-packed, illustrated booklet, write today to: The Celotex Corporation, Dept. MH-146, Chicago 3, Illinois.



Sound Conditioning with

ACOUSTI-CELOTEX

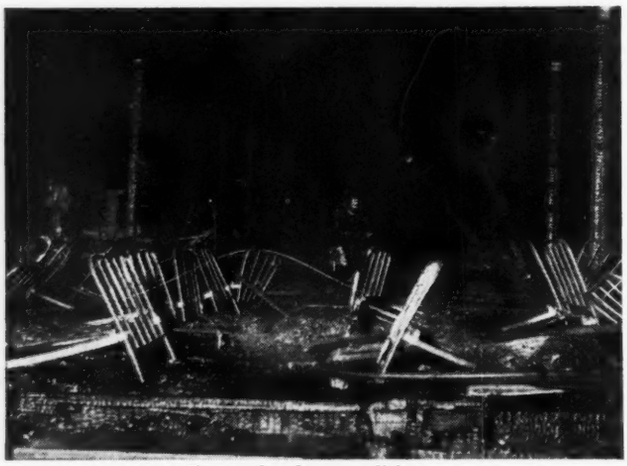
REG. U. S. PAT. OFF.

* *Perforated Fibre Tile* SINCE 1923

Sold by Acousti-Celotex Distributors Everywhere. • In Canada: Dominion Sound Equipments, Ltd.

Every Hospital and Institution can be made Fire-Safe

NOWHERE is peril of fire more feared than among those responsible for the helpless inmates of a hospital or institution. That this cause for fear is well founded is evidenced by a study of fifty hospital and institution fires in which lives were lost. The record shows an average loss of life per fire of 9.7 persons. Whereas this is somewhat lower than the 10.9 average for schools it is much higher than the average of 2 per fire in dwellings and 6 per fire in other types of structures.



Fire took a heavy toll here.

The following quotation from a history of hospital and institution fires published by the National Fire Protection Association indicates the concern with which this subject is regarded by a group whose purpose is to reduce the fire toll in this country:

"Unfortunately there still are many who have no conception of the seriousness of the fire problem. Safety to life from fire in hospital and institutional buildings requires that those responsible give attention to and take adequate measures to meet their responsibilities in all details affecting the safety of patients. They should realize that the protection of the sick and helpless against loss of life by fire or smoke is a responsibility of importance comparable to that of medical attention."

Much has been written about fireproof construction of hospitals. The impression is easily gained that danger to patients is removed when modern fireproof materials are used. Yet the percentage of fires and loss of life in these fireproof buildings ranks high.

Too little thought is given to the combustible nature of hospital contents — anesthetics, supplies, rubbish, electrical appliances, heating and kitchen equipment. Too often, *fireproof* hospitals have become *stoves* in which human life and valuable property were destroyed.

If this danger exists in so-called fireproof hospitals, what about older hospitals where even the structure itself is highly combustible? The answer is simple — danger of catastrophe is multiplied.

"What can be done about it?" is your logical question.

Fortunately, experience has proved that there is one sure way of protecting any building, new or old, against fire. It is a way that operates automatically, instantly and without human supervision. It is automatic sprinkler fire protection — which controls fire automatically as soon as it starts, before it reaches dangerous proportions. It is adaptable to older non-fireproof buildings and protects modern *fireproof* hospital structures against fires starting in inflammable contents.

To replace an existing building today would probably cost at least 50% more than its original cost. Even full-value insurance will leave you far short of necessary replacement funds.

The total cost of making a non-fireproof building fire-safe by the installation of an automatic sprinkler system is but a small percent of its value. Easy quarterly payment schedules brings the cost of this dependable protection well within the means of any hospital or institution.

That such a system can be installed without disturbance of patients and unsightly results to architecture is proved

Safety from fire is assured by this Automatic Sprinkler System.

by the experience of scores of hospitals that have taken this important step toward protection of life and property.

When consideration is given to the fact that hospital fires in the United States occur on the average of one each day, the importance of adequate, automatic means of protecting life becomes increasingly apparent. Those responsible for safeguarding life and property will find much of interest in a booklet, "Sprinklers Provide Safety to Life from Fire" reprinted from the January 1945 quarterly of the National Fire Protection Association. A copy of this booklet may be had by writing to the Grinnell Company, Inc., Providence 1, Rhode Island.

(ADVERTISEMENT)

AFTER HOURS

Advertising Was Their Insurance

As WE LOOK BACK on the war years, particularly in our own business, we are gratified to observe that advertising has been called upon to justify itself before the cold judgment of the reading public and that it has come through with honor. It is news today that many famous American industrial names are once again appearing in the market places. Familiar products are reappearing.

It is significant that these new products are announced in confidence that the American buyer will accept them now as he did before the war. That this is true is due to the fact that these honored names were kept everlastingly before the consumer even during the days when their owners had nothing to sell except a hope for the future and a promise that war's end would once again find them affixed to merchandise of known and proved quality.

That the consumer benefits by this kind of advertising may not be immediately apparent. In the most rigid economic sense such advertising does not at once perform its function of expediting mass marketing and cost reduction through mass production. It does, nevertheless, sustain the reputation of the leaders. It does constantly reassert the good faith of the producer. And it definitely maintains a market ready to buy when goods are once more available.

Thus the kind of advertising of which we have seen so much in recent years, labeled in the advertising business as "institutional" or "good will" advertising, performs much the same function as does the U. S. Patent Office in protecting the public. It is the attitude of the patent office, not so much that the owner of a trade mark shall be protected in his mark as that the public shall know what it buys under that mark. Trade mark infringement, of course, damages the mark owner and the government does, in fact, act as a registry of prior use against such damage. But primarily the registry of a trade mark serves to identify a product of known quality and infringement becomes misleading to the buyer.

Advertising is the voluntary investment of the manufacturer in an insurance policy for the consumer. Under the terms of this policy the manufacturer undertakes to protect the buyer from the hazards of unknown and often inferior goods. A trade mark is of value only when it is known and its significance understood. It is a good thing, therefore, that manufacturers have seen to it, through advertising, that their marks remained known to a forgetful public. It is a good thing for the manufacturer and a good thing for the consumer that he can buy known and proved quality even though a war has intervened.

—THE PUBLISHER

What's New for Hospitals

JANUARY 1946 SUPPLEMENT TO THE MODERN HOSPITAL

Absorbable Gauze

An absorbable gauze made from oxidized cellulose, which forms a black, gelatinous mass in contact with hemoglobin and thus controls bleeding in surgical wounds, has been developed by Johnson and Johnson. The gauze is designed to be left in the wound as it is gradually absorbed and so disappears. **Johnson & Johnson, Dept. MH, New Brunswick, N. J. (Key No. 2918)**

Aluminum Furniture

Modern furniture for the waiting room, lounge, nurses' home and similar locations is now available in aluminum. An easy chair and davenport have just been announced. Both are spacious with graceful lines, black hard rubber arm rests and seat cushions and backs of du Pont maroon Cavalon leatherette. Individual coil springs with felt and hair in the cushions make for restful comfort. These items offer high utility value and long life. **Doehler Metal Furniture Co., Inc., Dept. MH, 192 Lexington Ave., New York 16. (Key No. 2929)**

Redi-File

A new type of hanging file folder designed to fit any size desk drawer or standard filing drawer is known as Redi-File. Hanging folders with angle tabs make papers easy to locate in the executive's desk drawer or with any filing method. Folders cannot sag or bind and the arrangement obviates the necessity for follower block to hold papers upright. **Systems and Methods Research Dept., Remington Rand, Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 2925)**

Lighted Electric Outlet Plate

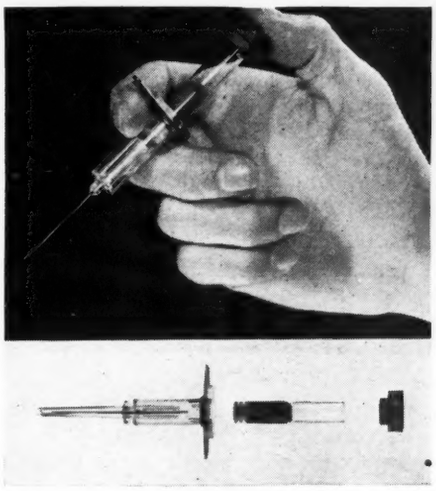
To aid in locating electric outlet plates quickly, the new LumiNite Duplex Convenience Outlet Plate has a tiny shielded electric bulb that is always lighted and emits a soft glow. This can also serve as a safety or night light. The plate is designed for quick installation and is molded of ivory plastic. **Associated Projects Co., Dept. MH, 80 E. Long St., Columbus 15, Ohio. (Key No. 2878)**

Self-Retaining Retractor

A self-retaining retractor has been developed for use in the interlaminar approach to hernias of the intervertebral disc. Made of stainless steel or with chrome finish, this instrument is designed so that one blade hooks upon the interspinous ligaments and the other blade extends more deeply to retract the lumbar muscles. **Edward Weck & Co., Inc., Dept. MH, 135 Johnson St., Brooklyn 1, N. Y. (Key No. 2920)**

Disposable Syringe

A sterile disposable plastic syringe has been developed by Abbott Laboratories



for the administration of penicillin. The unit consists of a cartridge containing a single one c.c. dose of 300,000 units of penicillin calcium, Abbott, in oil and wax and the plastic syringe with a fixed, sterile needle.

The penicillin cartridge is slipped into the syringe and it is ready for use. No further sterilization is necessary, there is no possibility of needle block and the sterile unit, once used, is discarded. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 2775)**

Fixation Bone Pin

General Electric X-Ray Corporation is the sole distributor for a new, improved external fixation bone pin to be used with the Stader fracture splint. The pin consists of a combined pilot type drill and reamer to facilitate drilling cortical bone and ensure an exact fit between pin and bone. The fluted design of the pilot point and reamer allows escape of bone chips. The pin provides a new mechanical approach to efficiently drilling cortical bone with pins that can be left in place as a means of skeletal fixation. **General Electric X-Ray Corp., Dept. MH, 175 W. Jackson Blvd., Chicago 4. (Key No. 2888)**

Nitrate Slide Comparator

The Taylor-Betz Nitrate Slide Comparator is designed to determine nitrate concentration of boiler water where nitrate-hydroxide ratios are maintained to control tendencies toward caustic embrittlement. The set consists of a Taylor pH slide comparator base, a color standard slide with 9 standards, nitrate, test tubes, reagent, pipette, concentrated sulfuric acid, graduate and beaker. The set is so designed that the accuracy of the method is not affected by ions normally present in boiler water. **W. A. Taylor & Co., Dept. MH, 7300 York Rd., Baltimore 4, Md. (Key No. 2889)**

Combustibles Recorder-Controller

A new automatic analyzer and recorder of particular value to the engineering department of the hospital has been announced. The device provides a continuous graphic analysis of the combustibles content of a gaseous mixture. The unit is designed to be responsive to changes of .05 per cent combustibles and to be within .25 per cent sustained accuracy. **Bailey Meter Co., Dept. MH, 1050 Ivanhoe Rd., Cleveland 10, Ohio. (Key No. 2883)**

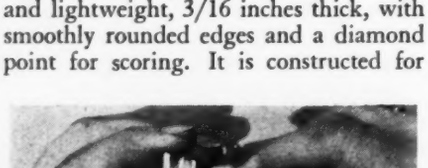
Lubricant

Slipit, a formula for lubricating doors, windows, drawers and similar items to prevent sticking, has been improved so that it has additional uses. Slipit now acts as a penetrant, rust inhibitor, polish, cutting oil and as a light, medium or heavy lubricant. It should prove of particular value in the housekeeping and maintenance departments of the hospital. **Slipit Products, Inc., Dept. MH, 169 Water St., New York. (Key No. 2792)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

Ampultator

The Ampultator is a device for quick and easy scoring of ampules. It is small and lightweight, 3/16 inches thick, with smoothly rounded edges and a diamond point for scoring. It is constructed for



years of efficient service. One complete turn of the ampule after being placed in position gives an even scoring and permits a fast, clean break. **Clay-Adams Co., Dept. MH, 44 E. 23rd St., New York 10. (Key No. 2919)**

Wilson Luminaire

The Wilson is the name of a new Pittsburgh Permaflector fluorescent luminaire recently designed and released. Featuring an egg crate louver bottom which eliminates dust in the unit, shields tubes and provides glareless illumination, the unit has side panels of Skytex glass. Four 40 watt fluorescent lamps are used and the length of the luminaire is 48⅛ inches. The unit can be surface or suspension mounted individually or in continuous rows. **Pittsburgh Reflector Co., Dept. MH, Oliver Bldg., Pittsburgh 22, Pa. (Key No. 2885)**

Redesigned Oxygen Tent

The Barach-Thurston Model M oxygen tent has been redesigned for increased efficiency and with more modern lines. The hinged door snaps into position when the lid is opened for re-icing. An advance in operating efficiency is provided through the automatic shutoff. When the door is opened the motor blower shuts off automatically, thus preventing loss of oxygen concentration within the canopy. The motor blower starts automatically as soon as the lid is closed, thus obviating the necessity to touch the control switches.

The cabinet has rounded corners and is sturdily built to hold as much as 80 pounds of broken ice. The lightness of weight, ease of motion and storage, silence of operation and careful construction of the original model have been retained. **Oxygen Equipment Mfg. Co., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 2875)**

Decker Culdoscope

Precise visual diagnosis with but little discomfort to the patient is possible through the use of the new Decker Culdoscope. Designed for accurate diagnostic procedures in the female pelvis, this new instrument consists of a right angle vision telescope providing a clear, sharp, undistorted image, a trocar fitted within a cannula for puncturing the cul-de-sac, a set of three cervical cones and flexible tube fitted with Luer lock connections. A conducting cord, a rotating contact, two blind rubber cystoscopic tips, a box of lamp wax and two replacement lamps are included with the instrument. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59. (Key No. 2867)**

Paint Brush Cleaner

A device for quickly cleaning paint brushes has been announced under the name Spin A Brush. A paint soaked brush is placed in turpentine or other solvent, then placed in the Spin A Brush for a few seconds where it is speedily revolved and comes out clean and free from paint. Spin A Brush can be operated on 110-115 volts A.C. or D.C. **Nashway Co. Ltd., Dept. MH, 1401 W. Pershing Rd., Chicago 9. (Key No. 2793)**

Vita-Snak Food Bar

Vita-Snak is the name of a chocolate coated food bar with an appealing flavor which contains twelve vitamins and eight minerals in quantities averaging more than the minimum daily requirements set forth in the regulations of the U. S. Food and Drug Administration. The bar was developed on the basis of research in food requirements for service personnel during the war and is now being made available to civilians as a simple and pleasing source of supplementary vitamins and minerals. **Ryan Products Co., Dept. MH, 420 Lexington Ave., New York 17. (Key No. 2882)**

Sanding Machine

The Easy Sander is a new development in a rugged, portable electric unit for maintenance. Time is saved in using this device through the fast, straight line, reciprocating action which duplicates the back and forth motion of hand block sanding or rubbing. A simple snap action method makes it easy to change sanding pads quickly and the unit can be used for flat, curved, wet or dry work.

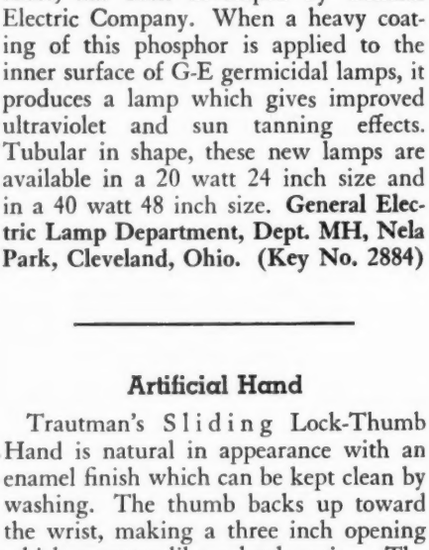
Weighing only seven pounds, the Easy Sander has a 115 or 220 volt universal electric motor which operates from any A.C. or D.C. outlet. All moving parts are mounted on ball bearings and the drive mechanism is sealed and packed in grease. The new design and careful construction insure long life and ease of operation and performance. **Detroit Surfacing Machine Co., Dept. MH, 7433 W. Davison, Detroit 4, Mich. (Key No. 2886)**

Sunlamp

A new phosphor powder, which resembles that used in fluorescent light tubes, has been developed by General Electric Company. When a heavy coating of this phosphor is applied to the inner surface of G-E germicidal lamps, it produces a lamp which gives improved ultraviolet and sun tanning effects. Tubular in shape, these new lamps are available in a 20 watt 24 inch size and in a 40 watt 48 inch size. **General Electric Lamp Department, Dept. MH, Nela Park, Cleveland, Ohio. (Key No. 2884)**

Artificial Hand

Trautman's Sliding Lock-Thumb Hand is natural in appearance with an enamel finish which can be kept clean by washing. The thumb backs up toward the wrist, making a three inch opening which operates like a hook action. The



thumb closes against the first and second fingers, giving a three point contact. The hand is light, being made of laminated wood and rawhide, and is strong and durable. **Minneapolis Artificial Limb Co., Dept. MH, 410 Sixth Ave. So., Minneapolis 15, Minn. (Key No. 2931)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

PHARMACEUTICALS

White's Mol-Iron

A new product for the treatment of iron deficiency anemias has been introduced under the name White's Mol-Iron. A specially processed co-precipitated complex of molybdenum oxide and ferrous sulfate, the product is supplied in tablet form in bottles of 100 and 1000. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N. J. (Key No. 2935)**

Therapeutic Formula Vitamin Capsules

Squibb has released a new formula especially designed for the treatment of patients suffering from mixed vitamin deficiencies. Known as Therapeutic Formula Vitamin Capsules, the formula provides in each capsule 25,000 units vitamin A, 1000 units vitamin D, 5 mg. thiamine hydrochloride, 5 mg. riboflavin, 150 mg. niacinamide and 150 mg. ascorbic acid. It is available in bottles of 100. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 2940)**

Nutritive Capsules

Parke-Davis Nutritive Capsules are a mineral-vitamin preparation providing a convenient supplementary source of calcium, phosphorus, iron and vitamins B_1, B_2 and D. They are useful during pregnancy and lactation, during convalescence and in cases of general malnutrition and are packed 100 and 1000 to the bottle. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 2937)**

Atropine Sulfate

Atropine Sulfate 1 per cent in a water miscible, rapidly spreading base, has been developed for use in iritis and eye injuries where prolonged dilation of the pupil is desired. Atropine Sulfate 2 per cent with boric acid 5 per cent in a similar base is offered for a similar type of case where a mild antiseptic is desired. Both products are supplied in 1 dram tubes with applicator tips. **Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 2752)**

Digitoxin

In Cardigin (Digitoxin "National") a purified, highly potent digitalis principle is made available for oral administration. Each tablet of Cardigin contains 0.2 mg. of Digitoxin "National" and research indicates that nausea and vomiting, even after the single full digitalization dose, are rare. **National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 2843)**

Medi-Sweet Baby Oil

Medi-Sweet Baby Oil is a new product scientifically formulated to have the minimum amount of skin irritation possible in cleansing, lubricating and protecting the skin of babies. Made with a base of mineral oil combined with corn oil, Medi-Sweet employs chlorothymol with a phenol coefficient of 120 as the antiseptic agent.

The oil provides a thin, nongreasy film which protects the skin and keeps it soft and smooth, reducing the incidence of skin irritations. **Children's Pharmacal Co., Dept. MH, 308 W. Washington St., Chicago 6. (Key No. 2933)**

Potassium Thiocyanate

Enseals Potassium Thiocyanate have been developed by Eli Lilly and Company for the treatment of hypertension. Prolonged research has indicated the effectiveness of the product in relieving the symptoms of hypertension and, in some cases, in lowering the blood pressure. The product is available in 1 grain or 3 grain tablets in bottles of 100, 500 and 1000. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 2840)**

Lorthio

Lorthio is the name of a new pediculicide especially effective against head lice although it is also destructive to body lice. The product is designed to act quickly and effectively against lice and their eggs. It has no objectionable odor due to the fact that it contains balsam pine among its component parts. **George A. Breon & Co., Dept. MH, P. O. Box 769, Kansas City 10, Mo. (Key No. 2897)**

Fibrin Foam and Thrombin

Military doctors have found fibrin foam invaluable in brain, liver, kidney and spleen surgery, using it as a surgical sponge in delicate operations in highly vascular areas. Because it is derived from human blood and contains natural protein constituents, fibrin foam can be left in the wound where it is gradually absorbed by the system.

The product is now available for civilian use. Cutter Laboratories offer Fibrin Foam and Thrombin (Human) in three-bottle sets, one containing fibrin foam, one thrombin which acts as the coagulating agent and one the diluent for the thrombin. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 2939)**

RECENT CATALOGS AND BOOKLETS

• Colored, durable wax models of various foods are available in paper cups and containers for the use of dietitians and other instructors in demonstrating the relationship of food and health. Details are contained in a leaflet entitled **"Dramatize Nutrition With Realistic Food Models"** issued by the Public Health Committee of the Paper Cup and Container Institute, 1790 Broadway, New York 19. **(Key No. 2910)**

• A profusely illustrated and attractive booklet, ADV. 430, has been issued by Republic Steel Corp., Advertising Division, 3100 E. 45th St., Cleveland 4, Ohio. Featuring **Enduro Stainless Steel "In War—In Peace,"** the booklet shows the uses of this product in the war effort and also features its use for hospital equipment and food serving and cooking equipment. **(Key No. 2949)**

• A 36 page catalog describing and illustrating parts and equipment needed by the maintenance crew of the hospital is entitled **"Modern Motor-Generator Maintenance and Repair Equipment for Reconditioning War Weary Machinery."** Much helpful information is contained in this booklet published by Ideal Commutator Dresser Co., Sycamore, Ill. **(Key No. 2848)**

• Microphotography of records by the use of the new Pathé Film Recorder and their study with the Pathé Film Reader are discussed in a leaflet prepared by the Microfilm Division of Pathé Mfg. Corp., 164 Duane St., New York 13. This **"Improved Method of Document Reproduction in Miniature Photography"** simultaneously photographs both sides of documents, is simple to operate and is contained in a streamlined, modern cabinet which blends with other office furniture. **(Key No. 2906)**

• A case history giving facts, figures and installation drawings and showing how fuel, energy and equipment were saved by the application of **Dorex Air Recovery** equipment to an air conditioning system is the subject of a new data folder issued by the W. B. Connor Engineering Corp., 114 E. 32nd St., New York 16. Data on ventilation requirements and a typical cost comparison chart on a new installation are included. **(Key No. 2909)**

• **The Infirmary Wheeler** is the new name for the giant size mobile Fibrcan receptacle manufactured by the Fibrcan Corp., Whitestone, L. I., N. Y. Full information on this product, its construction and its use in hospitals, is contained in a new folder recently issued by the company. **(Key No. 2946)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 248

• A new folder has recently been issued by Applegate Chemical Co., 5630 Harper Ave., Chicago 37, featuring **Marking Equipment and Supplies.** Information on the motor power marker and samples of the various types of lettering available are included. **(Key No. 2947)**

• **"Comfort Comes First"** is the title of a pamphlet illustrating and describing the line of aluminum chairs for every seating requirement and aluminum tables manufactured by the General Fireproofing Co., Youngstown 1, Ohio. **(Key No. 2942)**

• The various forms in which sponge rubber is manufactured and the many uses to which it can be put, from construction items to upholstering and filtering, are described in a circular on **"Cellular Rubber"** issued by the Sponge Rubber Products Co., Derby Place, Shelton, Conn. **(Key No. 2903)**

• **"The Principle and Practice of Smoothage in Constipation Therapy"** is the title of an informative booklet prepared by the Medical Dept. of G. D. Searle & Co., P. O. Box 5110, Chicago 80. **(Key No. 2861)**

• Two educational films which should have particular interest for the members of the hospital staff and for public relations use by the hospital are available through British Information Services, 30 Rockefeller Plaza, New York 20. The first, **"Accident Service,"** deals with accident services provided by the community and the second, **"Surgery in Chest Diseases,"** follows a patient from his appearance in a group for mass radiography through his diagnosis, operation and final discharge. **(Key No. 2854)**

• The **"Peabody CD Wide Range Oil Burning System"** is explained and described in a bulletin issued by Peabody Engineering Corp., 580 Fifth Ave., New York 19. The bulletin includes information on how the system achieves efficient combustion over a range in capacity as great as 50 to 1. **(Key No. 2902)**

• Of interest to maintenance executives as well as hospital administrators is a new folder issued by L. Sonneborn Sons, Inc., 88 Lexington Ave., New York 16. Entitled **"Lapidolith Liquid,"** the folder gives complete information on this chemical floor hardener which wearproofs and dustproofs concrete floors, terrazzo floors and other concrete surfaces. **(Key No. 2945)**

• The first edition of a new monograph, **"Sex Endocrinology for the Medical and Allied Professions,"** has just been issued by the Schering Corp., Bloomfield, N. J. **(Key No. 2943)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

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- ☐ 2793 Paint Brush Cleaner
- ☐ 2840 Potassium Thiocyanate
- ☐ 2843 Cardigin
- ☐ 2848 "Modern Motor-Generator Maintenance"
- ☐ 2854 "Educational Films"
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- ☐ 2867 Decker Culdoscope
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- ☐ 2882 Vita-Snak Food Bar
- ☐ 2883 Combustibles Recorder-Controller
- ☐ 2884 Sunlamp
- ☐ 2885 Fluorescent Luminaire
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- ☐ 2888 Fixation Bone Pin
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- ☐ 2918 Absorbable Gauze
- ☐ 2919 Ampultator
- ☐ 2920 Self-Retaining Retractor
- ☐ 2925 Redi-File
- ☐ 2929 Aluminum Furniture
- ☐ 2931 Artificial Hand
- ☐ 2933 Medi-Sweet Baby Oil
- ☐ 2935 White's Mol-Iron
- ☐ 2937 Nutritive Capsules
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- ☐ 2942 "Comfort Comes First"
- ☐ 2943 "Sex Endocrinology"
- ☐ 2945 "Lapidolith Liquid"
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- ☐ 2947 Marking Equipment and Supplies
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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

Manufacturers' Plant News

Elkay Mfg. Co. announces removal to their new plant at 1874 S. 54th Ave., Chicago 50, as of December 1, 1945. Greatly enlarged facilities are provided in the new plant for the manufacture of Elkay Sturdibilt Metal Products. **(Key No. 2951)**

Gomco Surgical Mfg. Co., Buffalo, N. Y., announces its removal to a new and greatly enlarged plant about January 1, 1946. In addition to approximately four times the floor space of the old quarters, the new plant has improved layout of production facilities and modern lighting for precision workmanship. **(Key No. 2952)**

The Marsh Heating Equipment Co., with main offices at 2122 Southport Ave., Chicago 14, is a combination of the James P. Marsh Corp. and the Marsh Tritrol Co. The new organization combines the distribution of Marsh Heating Specialties and the Marsh Tritrol Regulator, thus offering a better engineering and consulting service equipped to give consultation on all phases of heating problems—heat distribution and heat control. **(Key No. 2953)**

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